

MODEL



**DEPARTMENT OF
HEALTH**

AND HOSPITALS

Medicaid

PROVIDER AGREEMENT

BETWEEN

**THE LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING**

AND

Name of CCN-S

**FOR THE PROVISION OF SERVICES IN THE
LOUISIANA MEDICAID COORDINATED CARE PROGRAM**

August 30, 2010

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Provider Agreement for Coordinated Care Networks – Shared Savings

This Provider Agreement is between the Louisiana Department of Health and Hospitals – Bureau of Health Services Financing and _____ (name of Coordinated Care Network) for the provision of enhanced primary care case management services under Medicaid’s Coordinated Care Network – Shared Savings Program. This agreement is in compliance with 45 CFR § 92.36(a).

This Provider Agreement is entered into as of the first day of _____ (month), 20__, between the Department of Health and Hospitals, hereinafter referred to as "DHH" and the Coordinated Care Network – Shared Savings, hereinafter referred to as “CCN” or “CCN-S”.

1 GENERAL PROVISIONS

1.1 Effective Date and Term

The Provider Agreement (which includes the PE-50/CCN-S and its appendices), hereby incorporated, contains all of the terms and conditions agreed upon by the parties.

This Provider Agreement shall be effective the date the CCN successfully completes the CCN Enrollment Process (*See CCN-S Policy and Procedure Guide*) and is approved by DHH. The term period of the Provider Agreement shall begin on the initial date of service implementation, as specified by DHH, for a three (3) year commitment from the initial date of start up; unless terminated prior to that date in accordance with state or federal law or terms of the Provider Agreement.

Upon mutual agreement of both parties, this Provider Agreement may be renewed for subsequent three (3) year periods.

The CCN is aware of all documents referenced in this Provider Agreement. These documents are on file in DHH’s Medicaid Library.

1.2 Notices

Whenever notice, as specified in this Provider Agreement (e.g. termination or amendment) is required to be given to the other party, it shall be made in writing and delivered to that party. Delivery shall be deemed to have occurred if made in person and a signed receipt is obtained or three (3) calendar days have elapsed after posting if sent by registered or certified mail, return receipt requested.

Notices shall be addressed as follows:

Provider Agreement for Coordinated Care Networks – Shared Savings

In case of notice to CCN:

In case of notice to DHH:

Louisiana Department of Health and Hospitals
Bureau of Health Services Financing
628 North Fourth Street
Post Office Box 90130
Baton Rouge, Louisiana 70821-9030
Attn: Medicaid Coordinated Care Section Chief

Either party may change its address for notification purposes by mailing a notice stating the change, effective date of change and setting forth the new address at least ten (10) days prior to the effective date of the change of address. If different representatives are designated after execution of this Provider Agreement, notice of the new representative will be given in writing to the other party and attached to originals of this Provider Agreement.

1.3 Definitions

The terms used in this Provider Agreement shall be construed and interpreted as defined in *Appendix A – Definition of Terms* unless the context clearly requires otherwise.

1.4 Entire Agreement

The CCN shall comply with all provisions of the Provider Agreement including addenda, amendments and appendices and shall act in good faith in the performance of the provisions of said Provider Agreement. The CCN shall be bound by Louisiana Medicaid policy as stated in applicable provider manuals, the *CCN-S Policy and Procedure Guide*, any and all *Companion Guides*, and any updates or amendments thereto. The CCN agrees that failure to comply with the provisions of this Provider Agreement may result in the assessment of monetary penalties, sanctions and/or termination of the Provider Agreement in whole or in part, as set forth in this Provider Agreement. The CCN shall comply with all applicable DHH policies and procedures in effect throughout the duration of this Provider Agreement period. The CCN shall comply with all DHH provider manuals, policy and procedure guides, rules and regulations, and bulletins relating to the provision of services under this Provider Agreement. Where the

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provisions of the Provider Agreement differ from the requirements set forth in the handbooks and/or manuals, the Provider Agreement provisions shall control.

DHH, at its discretion, will issue Medicaid bulletins to inform the CCN of changes in policies and procedures which may affect this Provider Agreement. Unless a longer period is specified in the Medicaid Bulletin, the CCN will be given sixty (60) days to implement such changes. DHH is the only party to this Provider Agreement which may issue Medicaid bulletins.

1.5 Federal Approval of Provider Agreement

Prior approval of Primary Care Case Management arrangements by CMS is not required, however, the CMS Regional Office may request to review and approve all CCN Provider Agreements.

1.6 Renewal

This Provider Agreement may be renewed for an additional three year period whenever either of the parties hereto provides the other party with one hundred and twenty (120) calendar days advance notice of intent to renew and written agreement to renew the Provider Agreement is obtained from both parties. Either party may decline to renew this Provider Agreement for any reason. The parties expressly agree there is no property right in this Provider Agreement.

1.7 Amendments

This Provider Agreement may be amended at anytime as provided in this paragraph. This Provider Agreement may be amended whenever appropriate to comply with state and federal requirements, state budget reductions and/or as deemed necessary by DHH. No modification or change of any provision of the Provider Agreement shall be made or construed to have been made unless such modification is mutually agreed to in writing by the CCN and DHH, and incorporated as a written amendment to this Provider Agreement prior to the effective date of such modification or change.

1.8 Overview

Beginning in 2011, DHH will phase-in implementation of services through Medicaid's Coordinated Care Program. The Coordinated Care Network-Shared (CCN-S) Savings service delivery model is one of two new service delivery models being simultaneously implemented and is an enhancement to DHH's existing Medicaid primary care case management program known as CommunityCARE.

Provider Agreement for Coordinated Care Networks – Shared Savings

The initial implementation of the Coordinated Care Program will be phased in based on DHH's administrative regions. (See *CCN-S Policy and Procedure Guide* for Implementation Schedule).

A Shared Savings CCN (CCN-S) differs from the current CommunityCARE program in that the CCN is a primary care case manager that provides enhanced primary care case management in addition to being the entity contracting with primary care providers (PCP) for PCP care management. The CommunityCARE program enrolls primary care providers to provide primary care services. In addition, they provide referrals for specialty services and post-authorize lower level emergency room visits (CPT codes 99281 and 99282). The CCN-S will expand the current roles and responsibilities of the primary care providers through the establishment of patient-centered medical homes and create a formal and distinct network of primary care providers to coordinate the full continuum of care while achieving budget and performance goals and benchmarks.

Through this Provider Agreement, the CCN and their network of providers will provide DHH with the ability to ensure accountability while improving healthcare access, coordinating care and promoting healthier outcomes.

CCNs are a part of the continuum in DHH's strategy to move toward a more accountable, quality focused model of care. This effort is in line with national health care reform efforts to control cost, provide greater access to quality health care services and accountability both at the provider and Medicaid enrollee level.

The CCN shall provide a patient-centered medical home system of care for DHH, in accordance with this Provider Agreement and *CCN-S Policy and Procedure Guide*. The CCN must demonstrate the capacity to manage targeted populations identified in *Section 6.1- Enrollment Populations* through:

- a. The location, coordination and monitoring of primary health care services;
- b. Patient-Centered Medical Homes and care management;
- c. Quality management;
- d. Customer service;
- e. Provider network development and referrals;
- f. Prior authorization; and
- g. Monitoring and Reporting.

The CCN shall be responsible for network provider monitoring to ensure requirements such as, but not limited to, access to care; primary care provider's compliance with CCN policies; and progress of practices in implementation of patient-centered medical homes. The CCN shall provide participating primary care

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practices with support (e.g. education, training, tools, and provision of data relevant to patient clinical care management, systems development) necessary to transition primary care practices to patient-centered medical homes recognition as specified in the *CCN-S Policy and Procedure Guide* and facilitate data interchange between practices and the CCN, and the CCN and DHH (e.g. performance measures).

DHH shall establish a per member per month (PMPM) rate to be paid to the CCN for enhanced primary care case management services and shall also include a specified minimum amount for primary care provider (PCP) care management services, which shall not be subject to negotiation or dispute resolution. The amount of the enhanced primary care case management fee will be dependent upon the eligibility category the individual is assigned by Medicaid (e.g. Families/Children or SSI/Pregnant Women/Foster Children). The rate will be prospectively paid on a PMPM basis; however, up to fifty percent (50%) is subject to repayment to DHH if a predetermined savings benchmark is not achieved. The PMPM rate is intended to cover required enhanced primary care case management services under this Provider Agreement. The CCN will be responsible for components and services that include but are not limited to:

- PCP Patient-Centered Medical Home Recognition
- Member and Provider Services
- PCP Care Management
- Chronic Care Management
- Utilization Management
- Quality Management and Compliance
- Prior Authorization
- Provider Network Development and Referrals
- Provider Monitoring
- Fraud and Abuse Monitoring
- Account Management and Overhead

The CCN is responsible to pay a minimum of \$3 per member per month (PMPM) of the enhanced primary care case management fee to the PCP for his/her role in providing care management. The CCN will pay this amount on a monthly basis through the PCP care management fee for each individual assigned to the PCP. The total amount of the PCP

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care management fee paid to the PCP may be dependent upon the patient-centered medical home recognition level achieved by the PCP, as certified by the CCN and/or recognized by the National Commission for Quality Assurance (NCQA).

A CCN must meet the following prerequisite criteria in order to participate as a CCN-S provider in DHH's Coordinated Care Program:

- a. Meets the PCCM definition as defined in 42 CFR § 438.2;
- b. Be certified by the Louisiana Secretary of State to do business in the State of Louisiana;
- c. Be licensed or authorized as a Medical Necessity Review Organization (MNRO) from the Louisiana Department of Insurance (DOI) or contract with a Louisiana DOI licensed/authorized MNRO;
- d. Have the capability to preprocess claims (with the exception of carved-out services) and transfer data to DHH's fiscal intermediary (FI) or have a contract with an entity to perform these functions;
- d. Provide financial documentation of a minimum net worth of one million dollars (\$1,000,000) as specified in *Section 2.5 – Minimum Net Worth*;
- e. Post a Performance Bond in the amount of one million dollars (\$1,000,000) or submit an irrevocable letter of credit for one million dollars (\$1,000,000);
- f. Have network capacity to enroll a minimum of 15,000 Medicaid eligibles statewide into the network; and
- g. Successfully complete the CCN-S Enrollment Process (*See CCN-S Policy and Procedure Guide*).

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2 FINANCIAL MANAGEMENT

2.1 Reimbursement

DHH, or its fiscal intermediary, shall make payments to the CCN based on an established monthly enhanced primary care case management rate for each enrollee in the CCN, and share of savings, if any. The enhanced primary care case management rate schedule is provided in *Appendix D - Schedule of Enhanced Primary Care Case Management Fee Rates*. In order to be eligible to receive these payments, the CCN must enter into a Provider Agreement with DHH and remain in compliance with all provisions contained in this Provider Agreement.

The CCN shall enroll as a Louisiana Medicaid provider (PE 50) and as per 42 CFR § 438.106 (a),(b) and(c), agree to accept, as payment in full, the amount established by DHH pursuant to this agreement, and shall not seek additional payment from a member, or the Department, for any unpaid cost.

Claims payment for CCN-S members will continue to be paid by the FI through the fee-for-service system. After actual medical costs and the enhanced primary care case management fees are reconciled against the established per capita prepaid benchmark (PCPB), savings, if any, shall be shared between the CCN and DHH. Consistent with the approved 1932 State Plan Amendment, savings shared with the CCN are limited to five percent (5%) of the combined actual medical costs and the enhanced primary care case management fees. The amount of shared savings for which the CCN is eligible is also contingent upon quality performance measure outcomes. If the aggregate of actual medical costs and enhanced primary care case management fees (excluding amounts paid to the PCPs) are greater than the PCPB, the CCN may be required to return up to fifty percent (50%) of the enhanced primary care case management fee payments.

2.1.1 CCN Enhanced Primary Care Case Management Fee

The enhanced primary care case management fee provides for the functions of the enhanced primary care case management and PCP care management.

2.1.1.1 CCN Enhanced Primary Care Case Management Fee Rate

The enhanced primary care case management fee rate shall depend on the Medicaid eligibility group of the enrollee. (See *Appendix G - Enhanced Primary Care Case Management Fee Crosswalk*).

2.1.1.2 PCP Care Management Fee

The PCP care management fee will be paid to a PCP for care management services (e.g. care coordination, referrals) of each member linked to the PCP.

The CCN shall reimburse each PCP a monthly minimum rate of \$3.00 PMPM for each enrollee assigned to the PCP. The CCN may reimburse each PCP an amount greater than but not less than \$3.00 PMPM, unless mutually agreed upon by the PCP and the CCN. The CCN shall notify DHH of any downward adjustment in the \$3.00 PMPM PCP care management fee to the individual PCP. The difference in the agreed upon PMPM and the \$3.00 PMPM shall be refunded to DHH. The CCN shall report to the Department amounts paid to the PCP as specified in the *CCN-S Policy and Procedure Guide*.

In order to be eligible to receive the maximum agreed upon PCP PMPM payments, the PCP must enter into a contract with the CCN, meet performance measure goals and remain in compliance with all provisions contained in the contract. The CCN shall notify DHH of any reduction to the PCP's PMPM paid to the PCP due to non-compliance as specified in the *CCN-S Policy and Procedure Guide*.

The CCN shall not discriminate in the payment of the PCP care management fee and shall treat financially-related parties the same as non-financially related parties.

The CCN shall be liable to reimburse the predetermined PMPM PCP care management fee owed to the PCP(s) and all costs incurred to issue payments to the PCPs in the timelines specified by DHH for such reimbursement.

2.1.2 CCN Payment for Newborns and Deceased Members

The entire enhanced primary care case management fee payment will be paid during the month of birth and month of death. No proration adjustment to the enhanced primary care case management fee payments will occur to reflect eligibility for a partial month.

2.1.3 CCN Payment Schedule

The PMPM payment shall be based on member enrollment and paid on the dates indicated in the *CCN-S Policy and Procedure Guide, Appendix X - Fiscal Intermediary Payment Schedule*. Member enrollment is determined by linkages as of the third (3rd) to last business day of the previous month. CCN shall make payments to its providers as stipulated in this Provider Agreement and *CCN-S Policy and Procedure Guide*.

The CCN shall agree to accept payments as specified in this section and have written policies and procedures for receiving and processing PMPM payments and adjustments. Any charges or expenses imposed by a financial institution for transfers or related actions shall be borne by the CCN.

2.1.4 Payment Adjustments

In the event that an erroneous payment was made to the CCN, DHH shall reconcile the error by adjusting the CCN's next monthly enhanced primary care management fee payment.:

- a. Retrospective adjustments to prior payments may occur when it is determined that a member's aid category is retroactively changed. Payment adjustments may only be made when identified within twelve (12) month from the date of the member's aid category change for all services delivered within the twelve (12) month time period.
- b. When a payment is made for a deceased member for a month after the month of death.

2.1.5 Savings Determination

DHH will conduct periodic reconciliations to determine savings achieved or refunds due to DHH (from the enhanced primary care management fees). The reconciliation will compare the actual aggregate cost of authorized services as specified in *CCN-S Policy and Procedure Guide*, including the enhanced primary care management fee for dates of services in the reconciliation period, to the aggregate Per Capita Prepaid Benchmark (PCPB). The PCPB will not include the PCP care management fees described in § 2.1.1.2 above. In the event a member transitions from CCN mandatory or voluntary status to excluded status before being discharged from the hospital, the cost of the entire

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admission will be included in the actual cost when performing the savings reconciliation. Costs of nursing home, dental, personal care services (EPSDT and LT), hospice, services provided by a school district and billed through the intermediate school district, EarlySteps services, targeted case management, non-emergency medical transportation, specific specialized behavioral health drugs, and individual member total cost for the reconciliation year in excess of one hundred thousand dollars (\$100,000), will not be included in the determination of the PCPB nor will it be included in actual cost at the point of reconciliation so that outlier cost of certain individuals and/or services will not jeopardize the overall savings achieved by the CCN. The PCPB benchmark for each CCN will be risk-adjusted, if applicable, according to the risk profiles of members enrolled with the CCN.

DHH will perform interim and final reconciliations as of June 30th and December 31st of each year with provisions for Incurred-But-Not-Reported (IBNR) claims included in the actual cost. DHH reserves the right to make interim payments of any savings for any Dates of Service with more than 6 months elapsed time. A final reconciliation will be performed for any periods for which there are Dates of Service with more than 12 months elapsed time, at which point there should be sufficient completion of paid claims to determine total medical cost incurred by the CCN without the need to consider additional claims that have been incurred but are still outstanding. Final reconciliations will not be for less than 12 months (of service) unless determined appropriate by the Department.

In the first year of a CCN's operations, DHH will exclude claims from the first 30 days of operations when calculating the reconciliation.

- 2.1.5.1** In the event the CCN *exceeds* the PCPB in the aggregate (for the entire CCN enrollment), as calculated in the final reconciliation, the CCN will be required to refund up to 50% of the total amount of the enhanced care case management fees (excluding the PCP care management fee specified in §2.1.1.2 above) paid to the CCN during the period being reconciled.
- 2.1.5.2.** Such amounts shall be determined in the aggregate, and not for separate enrollment types.
- 2.1.5.3** CCN will be eligible for up to 60% of savings if the actual aggregate costs of authorized services, including enhanced primary care case management fees advanced, are less than

the aggregate PCPB (for the entire CCN enrollment). The enhanced care management fee will be reduced by \$3 PMPM during the reconciliation process. The \$3 PMPM component of the enhanced care management fee is equivalent to the \$3 PMPM primary care case management fee paid in FFS. Due to limitations under the Medicaid State Plan, shared savings will be limited to 5% of the actual aggregate costs including the enhanced care management fees paid. Such amounts shall be determined in the aggregate, and not for separate enrollment types.

2.1.5.4 During a CCN's first two years of operations, distribution of any savings will be contingent upon the CCN meeting the established "Early Warning System" performance measures and compliance under this Provider Agreement. After the second year of operations, distribution of any savings will be contingent upon the CCN meeting established performance measures and compliance with this Provider Agreement.

2.1.5.5 The CCN will be responsible for dividing the CCN's share of savings (if applicable) between the participating practices and itself, based upon any agreement established between the CCN and the practices.

2.1.6 Primary Care Provider Services Reimbursement

The CCN-S shall reimburse the PCP for PCP care management services. Claims payment for CCN-S members will continue to be paid by the FI through the fee-for-service system.

2.1.7 Return of Funds

The CCN agrees that all amounts owed to DHH, as identified through routine or investigative reviews of records or audits conducted by DHH or other state or federal agency, are due no later than 30 calendar days following notification to the CCN by DHH unless otherwise authorized in writing by DHH. DHH, at its discretion, reserves the right to collect amounts due by withholding and applying up to thirty percent (30%) balances due to DHH to future PMPM payments. DHH reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR §30.13. This rate may be revised quarterly by the

Secretary of the Treasury and shall be published by HHS in the Federal Register. In addition, the CCN shall reimburse all payments as a result of any federal disallowances or sanctions imposed on DHH as a result of the CCN's failure to abide by the terms of the Provider Agreement. The CCN shall be subject to any additional conditions or restrictions placed on DHH by the United States Department of Health and Human Services (HHS) as a result of the disallowance. Instructions for returning of funds shall be provided by written notice.

2.2 Workers' Compensation Insurance

Before the Provider Agreement is implemented, the CCN shall obtain, and maintain during the life of the Provider Agreement, Workers' Compensation Insurance for all of the CCN's employees employed to provide services under the Provider Agreement.

The CCN shall require that any contractor or contract providers obtain all similar insurance prior to commencing work.

The CCN shall furnish proof of adequate coverage of insurance by a certificate of insurance submitted to DHH as specified in the CCN Enrollment Process (*See CCN-S Policy and Procedure Guide*) and annually thereafter and upon change in coverage and/or carrier.

DHH shall be exempt from, and in no way liable for, any sums of money that may represent a deductible in any insurance policy. The payment of such a deductible shall be the sole responsibility of the CCN, contractor and/or provider obtaining such insurance.

Failure to provide proof of adequate coverage before work is commenced may result in this Agreement being terminated.

2.3 Commercial Liability Insurance

The CCN shall maintain during the life of this Provider Agreement such Commercial Liability Insurance which shall protect the CCN and DHH during the term covered by the Provider Agreement from claims for damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from services related to the Provider Agreement, whether such services are provided by the CCN or by its contractors, or by anyone directly or indirectly employed by either of them, or in such a manner as to potentially impose liability to DHH. In the absence of specific regulations, at a minimum, the amount and type of coverage shall include bodily injury, property

damage, errors and omissions, directors' and officers' coverage, and contractual liability, with combined single limits of one million dollars (\$1,000,000).

2.4 Performance Bond

Prior to the CCN Enrollment Process –Readiness Review, the CCN shall procure and submit a Performance Bond in the amount of one million dollars (\$1,000,000), or in lieu of a performance bond, the CCN may submit an irrevocable letter of credit for the required amount.

The bond must be obtained from an agent licensed in Louisiana and appearing on the United States Department of Treasury's list of approved sureties. The performance bond must be made payable to the State of Louisiana. The Provider Agreement and dates of performance must be specified in the performance bond. In the event that DHH exercises an option to renew the Provider Agreement for an additional period, the CCN shall be required to maintain the validity and enforcement of the bond for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of Provider Agreement renewal.

2.5 Minimum Net Worth Amount

It is the responsibility of the CCN to maintain minimum net worth amounts as described in this section. At the time the CCN enters into a Provider Agreement with DHH, it must provide documentation of a minimum net worth of one million dollars (\$1,000,000). A minimum of 75% of the net worth shall be maintained in cash or cash equivalents. The remaining amount required to meet the net worth requirements may consist of other assets as determined and valued by Generally Accepted Accounting Principles (GAAP).

The CCN shall re-evaluate their net worth six months following the initial implementation of service delivery. The CCN shall submit to DHH for approval, its re-evaluated net worth and all documentation utilized for this determination within 30 days after the initial six-month service delivery and annually thereafter or as determined necessary by DHH. The CCN shall maintain a minimum net worth amount equal to the greater of:

- a. \$1,000,000;
- b. Two (2) months of enhanced primary care case management fee payments based on the last two months of payments from DHH during the CCN's most recent audited fiscal period; or
- c. 8% of annual enhanced primary care case management revenue as reported on the most recent audited financial statements.

Should DHH determine the CCN is below the minimum net worth requirement, the CCN shall have thirty (30) days upon receipt of notification by DHH to meet the requirement set forth above. If the requirements are not met, the CCN shall be subject to sanctions as specified in §13 of this Provider Agreement.

2.6 Financial Reporting

The CCN shall submit to DHH unaudited quarterly financial statements and an annual audited financial statement. Quarterly financial statements shall be submitted no later than sixty (60) days after the close of each calendar quarter. Audited annual statements shall be submitted no later than six (6) months after the close of the CCN's fiscal year. All financial reporting shall be based on Generally Accepted Accounting Principles (GAAP).

The financial statements shall be specific to the operations of the CCN rather than to a parent or umbrella organization.

The CCN shall disclose amounts included in the financial statements pertaining to any person or entity with ownership or controlling interest of 5% or more in the CCN and any of its contractors, including all entities owned or controlled by a parent or subsidiary organization. Additional information shall be available to DHH regarding related party transactions at the request of DHH, including the cost of such services as incurred by the related party. This disclosure shall include, but not be limited to, amounts paid to related third party administrators, insurers, providers, vendors, contractors and individuals.

2.6.1 Upon submission of the Provider Agreement, the CCN shall:

- a. Attach copies of its financial statements for the past three (3) years. If the CCN is a subsidiary of a parent organization, the CCN shall submit its financial statements or those of its parent, whichever are available. If the CCN is a new entity, without a previous or parent entity, this requirement will be waived upon documentation of the performance bond and minimum net worth requirements. The financial statements must undergo an independent certified audit. The CCN is responsible for ensuring that this audit is performed. All audits shall include:
 1. The opinion of a certified public accountant;
 2. A statement of revenue and expenses;
 3. A balance sheet;
 4. A statement of changes in financial position; and
 5. A copy of all management letters;

- b. Provide the following pro forma financial statements for the CCN's Louisiana operation. The pro forma financial statements must be prepared on an accrual basis by month for the first three years beginning with the first month of the proposed execution date of the Provider Agreement:
 1. A statement of monthly revenue and expenses;
 2. A monthly cash flow analysis; and
 3. A balance sheet for each month;
- c. Provide copies of its bank statements for all its accounts;
- d. Provide a monthly enrollment and revenue projection corresponding to the pro forma financial statements referenced above; and
- e. The CCN shall provide a statement, signed by its president or chief executive officer, attesting that no assets of the CCN have been pledged to secure personal loans.

2.7 Proof of Insurance

At any time, upon the request of DHH or its designee, the CCN shall provide proof of insurance required in this Provider Agreement and the CCN shall be the named insured on the insurance policy or policies.

2.8 Fidelity Bonds

The CCN shall secure and maintain during the life of this Provider Agreement a blanket fidelity bond from a company doing business in the State of Louisiana on all personnel in its employment. The bond shall include, but not be limited to, coverage for losses sustained through any fraudulent or dishonest act or acts committed by any employees of the CCN and its contractors.

2.9 Surety Bond

Within sixty (60) days from the implementation date of the CCN, the CCN shall secure, pay for, and keep in force for the duration of the Provider Agreement, a surety bond equal to the at-risk portion of the enhanced care management fee, from a company doing business in the State of Louisiana.

The Provider Agreement and dates of performance must be specified in the surety bond. The surety bond must be maintained during the life of the Provider Agreement, including all renewal/extension periods, and maintained through

any shared savings calculations following termination of the Provider Agreement and final financial settlement. DHH may release the CCN from this requirement after the termination of the Provider Agreement if DHH determines the shared savings calculation does not result in any amount due DHH, performances measure thresholds have been meet, and there are no outstanding sanctions.

2.10 Errors and Omissions Insurance

The CCN shall obtain, pay for, and keep in force for the duration of the Provider Agreement period, Errors and Omissions insurance from a company doing business in the State of Louisiana in the amount of at least one million dollars (\$1,000,000) per occurrence.

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3 CCN ADMINISTRATION AND MANAGEMENT

3.1 CCN Administration and Management

The CCN shall be responsible for the administration and management of its requirements and responsibilities under this Provider Agreement and the *CCN-S Policy and Procedure Guide*, including all contracts, employees, agents, and anyone acting for, or on behalf of, the CCN. No contract or delegation of responsibility shall terminate the legal responsibility of the CCN to DHH to assure that all requirements are carried out.

The CCN shall have a centralized executive administration located in the State of Louisiana, which shall serve as the contact point for DHH, except as otherwise specified in this Provider Agreement.

The positions described below represent the minimum management staff requirements for the CCN. The CCN shall report changes in management staff to DHH within five (5) business days of the change. The CCN is responsible to ensure that all employees meet qualification requirements commensurate with their staffing position. The CCN is responsible for conducting background checks on all personnel and immediately providing the staffing plan(s) to DHH upon request. The CCN shall not make a change in key personnel as specified in the Provider Agreement, without the prior written consent of DHH.

3.1.1 Staff Requirements

The staffing for the CCN providing for enhanced primary care case management services under this Provider Agreement must be capable of fulfilling the requirements of this Provider Agreement, and in accordance this agreement and the *CCN-S Policy and Procedure Guide*. One person may be designated to multiple roles unless the staffing requirement is designated as full-time. The minimum staffing requirements are as follows:

3.1.1.1 Executive Director

The CCN shall designate an Executive Director to work directly with DHH. The Executive Director shall be an employee of the CCN with authority to revise processes or procedures and assign additional resources as needed to maximize the efficiency and effectiveness of services required under the Provider Agreement. The CCN shall meet in person, or by telephone, at the request of Department representatives to discuss the status of the Provider

Agreement, CCN performance, benefits to the state, necessary revisions, reviews, reports and planning.

3.1.1.2 Project Director

The CCN shall have a full-time Project Director (full-time administrator) specifically identified to administer the day-to-day business activities of the Provider Agreement. The CCN may designate the Executive Director, or Medical Director as the fulltime Project Director, but such person cannot also be designated to any other position in this section, including in other lines of business within the CCN, unless otherwise approved by DHH.

3.1.1.3 Medical Director

The CCN shall have a full-time (32 hours/week) physician with an active unencumbered Louisiana license in accordance with state laws and regulations to serve as Medical Director to oversee care management and be responsible for the proper authorization and provision of core benefits and services to Medicaid CCN members under this Provider Agreement. The Medical Director cannot be designated to serve in any other non-administrative position. The Medical Director must have substantial involvement in the Quality Assessment and Performance Improvement (QAPI) activities and shall chair the QAPI committee.

3.1.1.4 Clinical Services Coordinator

The CCN shall have a full-time RN , PA, or MD with an active, unencumbered Louisiana license in accordance with state laws and regulations to supervise care management staff.

3.1.1.5 Compliance Officer

The CCN shall have a designated person qualified by training and experience in health care or risk management, to oversee a fraud and abuse program to prevent and detect potential fraud and abuse activities pursuant to state and federal rules and regulations, and carry out the provisions of the compliance plan, including fraud and abuse policies and procedures, investigating unusual incidents and implementing any corrective action plans.

CCN must have a compliance committee that is, along with the compliance officer, accountable to senior management (e.g. CCN Project Director). The compliance officer shall have effective lines of communication with all the CCN's employees and contractors. (See monitoring and reporting requirements within the *CCN-S Policy and Procedure Guide*).

3.1.1.6 Quality Management Director and Staff

The CCN shall have a designated person, qualified by training and experience in Quality Management (QM) and who holds the appropriate clinical certification and/or license.

The CCN shall also have sufficient staff qualified by training and experience to be responsible for the operation and success of the QAPI. The QAPI staff shall be accountable for quality outcomes in all of the CCN's own network providers, as well as contract providers, as stated in 42 CFR §438.200 – 438.242.

3.1.1.7 Data Processing and Data Reporting Coordinator and Staff

The CCN shall have a person trained and experienced in data processing, data reporting, and claims resolution, as required, to ensure that computer system reports the CCN provides to DHH and its agents are accurate, and that computer systems operate in an accurate and timely manner.

Staff trained and experienced in data processing and data reporting as required to provide necessary and timely reports to DHH.

3.1.1.8 Medical and Professional Support Staff

The CCN shall have medical and professional support staff sufficient to conduct daily business in an orderly manner including having member services staff directly available during business hours for member services consultation, as determined through management and medical reviews. The CCN shall maintain sufficient medical staff, available twenty-four hours a day, seven days a week (24/7), to handle emergency services and care inquiries. The CCN shall maintain sufficient medical and professional support staff during non-business hours, unless the CCN's computer system automatically approves all emergency

services and claims relating to screening and treatment and support/education to promote implementation of patient-centered medical homes;

3.1.1.9 Utilization Management Staff

The CCN shall have sufficient utilization management staff, qualified by training, experience and certification/licensure to conduct the CCN’s utilization management functions.

3.1.1.10 Case Management/Chronic Care Management Staff

The CCN shall have sufficient case management and chronic care management staff, qualified by training, experience and certification/licensure to conduct the CCN’s case management and chronic care management functions.

3.1.1.11 Medical Records Review Coordinator

The CCN shall have a designated person, qualified by training and experience, to ensure compliance with the medical records requirements as described in this Provider Agreement and *CCN-S Policy and Procedure Guide*. The Medical Records Review Coordinator shall maintain medical record standards and direct medical record reviews according to the terms of this Provider Agreement and *CCN-S Policy and Procedure Guide*.

3.1.1.12 Claims Manager

The CCN shall have a designated person qualified by training and experience to oversee claims data submittal and processing and to ensure the accuracy, timeliness and completeness of processing payment and reporting.

3.1.1.13 Member Education and Marketing Coordinator

The CCN shall have a designated person, qualified by training and experience, to ensure the CCN adheres to the Member Education and Marketing requirements of this Provider Agreement and *CCN-S Policy and Procedure Guide*.

3.1.1.14 Grievance System Coordinator and Staff

The CCN shall have a designated person, qualified by training and experience, to process and resolve complaints, grievances and appeals and be responsible for the CNN's grievance system.

The CCN shall have sufficient support staff (clerical and professional) to process grievances and appeals within the required time frames and to assist complainants in properly filing grievances;

3.1.1.15 Positions to be Housed in Louisiana

The following positions shall be housed in the State of Louisiana:

- a. Project Director
- b. Medical Director
- c. Clinical Services Coordinator

3.1.1.16 Availability of Staff

All management staff must be available during DHH hours of operation and available for in-person meetings as requested by DHH.

3.1.2 Provider Licensing/Certification Requirements

All of the CCN's providers must be licensed and/or certified by the appropriate Louisiana licensing body or standard-setting agency, as applicable. All of the CCN's providers/contractors must comply with all applicable statutory and regulatory requirements of the Medicaid program and be enrolled in the Louisiana Medicaid program. The CCN shall be responsible for assuring that all persons, whether employees, agents, contractors, or anyone acting for on behalf of the CCN, are properly licensed at all times under applicable state law and/or regulations and are not terminated, excluded, suspended from or denied/denied renewal of participation in any Medicaid and/or Medicare Program.

Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services. Failure to adhere to this provision may result in one or more of the following sanctions:

3.1.2.1 DHH may refer the matter to the appropriate licensing authority for action; or

3.1.2.2 DHH may assess monetary penalties as described in **§13.3.1** or impose sanctions as described in **§13.3** of this Provider Agreement.

3.2 **Training**

The CCN shall be responsible for training all of its employees and network providers and/or contractors, to ensure that they adhere to the CCN policies and procedures and Medicaid rules and regulations. The CCN shall be responsible for conducting ongoing training on Medicaid and CCN Program policies and distribution of policy updates to its network providers/contractors. DHH reserves the right to attend any and all training programs and seminars conducted by the CCN. The CCN shall provide DHH a list of any training dates, time and location, at least fourteen (14) calendar days prior to the date of the event. The CCN shall maintain records of attendance of all training attendees and shall provide an electronic copy to DHH and/or its designee upon request.

3.3 **Liaisons**

The CCN shall designate an employee of its administrative staff to act as liaison between the CCN and DHH for the duration of the Provider Agreement. DHH's Medicaid Coordinated Care Section will be CCN's point of contact and shall receive all inquiries and requests for interpretation regarding this Provider Agreement, and all required reports unless otherwise specified in this Provider Agreement. The CCN shall also designate a member of its senior management who shall act as a liaison between the CCN's senior management and DHH when such communication is required. If different representatives are designated after approval of this Provider Agreement, notice of the new representative shall be provided in writing within five (5) business days of the designation.

3.4 **Material Changes**

The CCN shall notify DHH immediately of all material changes affecting the delivery of health care or the administration of services provided under this Provider Agreement. Material changes include, but are not limited to, changes in: composition of the provider network or contractor network, CCN's complaint and grievance procedures; health care delivery systems or services, geographic service area or payments; enrollment of a new population; procedures for

obtaining access to or approval for health care services; and the CCN's ability to meet their declared maximum enrollment levels (upward or downward movement in originally specified maximum enrollment levels). Changes must be approved in writing by DHH at least 30 days in advance of the proposed change implementation.

For those changes that were not within the control of the CCN, the CCN shall immediately notify DHH once it has knowledge of the change that will need to be made, but no later than seven (7) calendar days before the change, for approval. The CCN must provide documentation, with the approval request, of the events that caused the CCN to be unable to submit the change thirty (30) days in advance. DHH shall make the final determination as to whether the events were or were not within the control of the CCN.

The CCN must provide CCN Program members with a copy of all approved changes at least thirty (30) days prior to the intended effective date of the change. DHH shall make the final determination as to whether a change is material.

The CCN shall be responsible for all costs associated with any changes the CCN makes during the term of this Provider Agreement or during Provider Agreement termination. Costs associated with any changes may include, but are not limited to, costs incurred for name changes, for transitioning members from one provider to another during a transition or termination process, and costs incurred by the Enrollment Broker in updating its system and website to incorporate the changes.

3.5 Incentive Plans

The CCN shall establish an incentive plan for PCP practices that have achieved NCQA Physician Practice Connections[®] - Patient-Centered Medical Home (PPC-PCMH[™]) recognition. Incentive payments shall be determined according to the PPC-PCMH[™] level of recognition achieved by the PCP practice. The Incentive plan shall describe the process to calculate and distribute monthly incentive payments.

The CCN may develop additional incentive plans. All incentive plans for network providers shall be in compliance with 42 CFR §§422.208 and 422.210 Physician incentive plans: requirements and limitations. (See *CCN-S Policy and Procedure Guide*)

The CCN shall submit any information regarding incentives as may be required by DHH.

3.6 Notification of Legal Action

The CCN shall provide DHH immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the CCN's ability to perform under this Provider Agreement with DHH.

3.7 Fraud and Abuse Compliance Plan

The CCN must have administrative and management policies and procedures, including a mandatory compliance plan, that are designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in accordance with the requirements specified in this Provider Agreement and *CCN-S Policy and Procedure Guide*. The CCN will submit its Fraud and Abuse Compliance Plan to DHH during the enrollment process for approval by DHH and annually thereafter. Requests for revision(s) to the Plan must be submitted to and approved by DHH at least thirty (30) days prior to implementation of such revision(s).

These policies and procedures must include the following:

- 3.7.1 Written policies, procedures, and standards of conduct that articulate the CCN's commitment to comply with all applicable Federal and State standards and regulations;
- 3.7.2 The designation of a compliance officer and a compliance committee that is accountable to senior management and requirements for an adequately staffed compliance office;
- 3.7.3 Effective education for the compliance officer, the organization's employees, CCN providers, and members about fraud and abuse and how to report it;
- 3.7.4 Effective lines of communication between the compliance officer and the CCN employees, contractors, providers and DHH and/or its designee;
- 3.7.5 Enforcement of standards through well-publicized disciplinary guidelines (e.g. member/provider manuals, trainings, or newsletters, bulletins);

- 3.7.6 Provisions for internal monitoring and auditing of the CCN's providers, contractors, employees, and others;
- 3.7.7 Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this Provider Agreement; and
- 3.7.8 Procedures for timely and consistent exchange of information and collaboration with DHH Program Integrity Unit, Attorney General Medicaid Fraud Control Unit (MFCU), and DHH contracted EQRO regarding suspected fraud and abuse occurrences.

These policies, along with the designation of the compliance office and committee, must be submitted to DHH for approval upon initiation of this Provider Agreement and thirty (30) days prior to material changes.

The CCN must immediately report to DHH any suspicion or knowledge of fraud and abuse including, but not limited to, the false or fraudulent filings of claims and the acceptance of, or failure to return, monies allowed to be paid on claims known to be fraudulent. See the *CCN-S Policy and Procedure Guide* for additional guidance.

3.8 Ownership

The CCN shall provide full and complete information on the identify of each person or corporation with an ownership or controlling interest (5%+) in the CCN or any contractor in which the CCN has 5% or more ownership interest. The CCN shall provide such required information including, but not limited to financial statements, for each person or entity with ownership or controlling interest of 5% or more in the CCN and/or any of its contractors, including all entities owned or controlled by a parent organization. This information shall be provided to DHH on the approved Disclosure of Ownership Information Form and whenever changes in ownership occur.

3.9 Excluded Parties

The CCN shall be responsible for screening all providers, employees, and contractors through the Excluded Parties List Service administered by the General Services Administration, initially and monthly thereafter, when it enrolls any provider or contractor, to ensure that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in Federal procurement activities and/or have an employment, consulting, or other

agreement with debarred individuals for the provision of items and services that are significant to the CCN entity's Provider Agreement obligation. The CCN shall also report to DHH any network providers or contractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

3.10 Prohibited Affiliations with Individuals Debarred by Federal Agencies.
General Requirement

As per 42 CFR §438.610(a) and (b), a CCN may not knowingly have a relationship with the following:

- a. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549; or
- b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1).

The relationship is described as follows:

- a. A director, officer, or partner of the CCN;
- b. A person with beneficial ownership of five (5) percent or more of the CCN's equity.
- c. A person with an employment, consulting or other arrangement with the CCN under its contract with the State.

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4 ENHANCED PRIMARY CARE CASE MANAGEMENT SERVICES

The CCN shall possess the expertise and resources to ensure the delivery of enhanced primary care case management and PCP care management services to CCN members in accordance with the provisions of this Provider Agreement, *CCN-S Policy and Procedure Guide* and Medicaid rules and regulations. These services shall include, but not be limited to, referral to and coordination of authorized services to any of the Medicaid providers where a referral has been made; chronic care management; member services, and quality management.

4.1 Care Management

Care management is defined as the overall system of medical management encompassing, but not limited to, Utilization Management, Case Management, Care Coordination, Continuity of Care, Care Transition Chronic Care Management, and Independent Review. The CCN shall ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid authorized services provided to the member. The CCN shall be responsible for ensuring:

- 4.1.1** Member's health care needs and services care are planned and coordinated through the CCN PCP;
- 4.1.2** Accessibility of services and promoting prevention through qualified medical home practices in accordance with 42 CFR §438.6 (k) which requires the provision for reasonable and adequate hours of operation including 24/7 availability of information, referral, and treatment for emergency medical conditions; and
- 4.1.3** Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services without compromise to quality of care. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical and/or behavioral health services.

4.2 Referral System

The CCN shall have a referral system for CCN members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care. The CCN shall provide the

coordination necessary for referral of CCN members to specialty providers that are available through fee-for-service Medicaid providers. The CCN shall assist the member in determining the need for services outside the CCN network and refer the member to the appropriate service provider. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services (e.g., medications prescribed, treatment received, recommendations for care), and follow up are included in the PCPs member medical record. Refer to the *CCN-S Policy and Procedure Guide* for services that are exempt from referral requirements. The CCN may request the assistance of DHH for the names of specialists who accept Medicaid. The CCN shall submit referral system processes and guidelines to DHH as specified in the CCN Enrollment Process (See *CCN-S Policy and Procedure Guide*), and annually thereafter, for approval.

4.3 Care Coordination, Continuity of Care, and Care Transition

The CCN shall develop and maintain effective coordination, continuity of care, and care transition activities which ensure a continuum of care approach to providing health care services to CCN members. The CCN shall establish a process to coordinate the delivery of primary care services with other services that are reimbursed fee-for-service by DHH. The CCN shall ensure member-appropriate PCP choice within the CCN and interaction with providers outside the CCN. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which CCN members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The CCN shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that a CCN member may encounter.

4.4 Utilization Management

The CCN shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. UM program policies and procedures shall meet all Utilization Review Accreditation Commission (URAC) or National Committee for Quality Assurance (NCQA) utilization management standards. Refer to the *CCN-S Policy and Procedure Guide* for UM Program requirements and service authorization exceptions. The Network shall submit UM policies and procedures to DHH as specified in the CCN Enrollment Process (See *CCN-S Policy and Procedure Guide*) for approval. The UM Program shall:

- a. Have written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses to request a service or does not request a service in a timely manner;
- b. Have mechanisms to ensure consistent application of review criteria for authorizations decisions and consult with the requesting provider as appropriate;
- c. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
- d. Provide a mechanism in which a member may submit, whether verbally or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures.

4.4.1 The CCN shall provide for the following decisions and notices:

- a. In regard to standard authorization decisions, the CCN shall provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:
 - (i) The member, or the provider, requests extension;
or
 - (ii) The CCN justifies to DHH upon request a need for additional information and how the extension is in the member's best interest.
- b. Expedited authorization decisions

- (i) For cases in which a provider indicates, or the CCN determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 working days after receipt of the request for service.
- (ii) The CCN may extend the three (3) business day time period by up to fourteen (14) calendar days if the member requests an extension, or if the CCN justifies to DHH upon request a need for additional information and how the extension is in the member's best interest.

The CCN shall utilize Utilization Management practice guidelines that:

- a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- b. Consider the needs of the members;
- c. Are adopted in consultation with contracting health care professionals; and
- d. Are reviewed and updated periodically as appropriate.

The CCN shall disseminate Utilization Management practice guidelines to all affected providers, members, and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines

The CCN shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be authorized in an amount, duration, and scope that are no less than the amount, duration, and scope for the same services furnished to eligible individuals under the Medicaid State Plan (See *Appendix B – Louisiana State Plan Services*). The CCN:

- a. Shall ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished;

- b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member; and
- c. May place appropriate limits on a service (a) on the basis of certain criteria, such as medical necessity; or (b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

4.5 Case Management

The CCN shall develop and implement a case management program through a process which provides that appropriate and cost-effective medical services, medically-related services, other services, and behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate and cost-effective service plan that meets the medical, functional, and behavioral health needs of the member. The case manager should assist/facilitate the discharge planning process when assistance is needed to ensure patients receive care deemed medically necessary by the treating physician. The CCN shall submit case management program policies and procedures to DHH for approval as specified in the CCN Enrollment Process (*See CCN-S Policy and Procedure Guide*) and annually thereafter. See Section §4.9.1 of this Provider Agreement regarding care coordination for special populations.

4.6 Chronic Care Management Program (CCMP)

The CCN shall implement a Chronic Care Management Program (CCMP) as identified in the *CCN-S Policy and Procedure Guide* for members with chronic conditions. The Chronic Care Management Program shall:

- a. Emphasize prevention of exacerbation and complication of chronic diseases utilizing evidence based clinical practice guidelines and patient empowerment and activation strategies;
- b. Encourage the evaluation of clinical, humanistic and economic outcomes;
- c. Address co-morbidities through a whole-person approach; and

- d. Promote chronic care management strategies, such as: referral processes; after hours protocols, and targeted management to focus on those in greatest need.

4.7 Quality Management

The CCN will establish and implement a Quality Assessment and Performance Improvement (QAPI) program as specified in the *CCN-S Policy and Procedure Guide*. The CCN shall submit a QAPI Quality Assessment Work plan as specified in the CCN Enrollment Process (*See CCN-S Policy and Procedure Guide*), and annually thereafter, for DHH review and approval. The plan must include mechanisms to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to members with special health care needs. The CCN shall have a process in place to evaluate the impact and effectiveness of its QAPI program. DHH must approve any material change to this plan prior to implementation of the revisions. Refer to the *CCN-S Policy and Procedure Guide* for QAPI program requirements.

The CCN will agree to an External Quality Review, review of Quality Assessment Committee meeting minutes, and annual medical audits to ensure that CCN providers provide quality and accessible health care to CCN members, in accordance with standards contained in the *CCN-S Policy and Procedure Guide* and under the terms of this Provider Agreement. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to surveys and other information concerning the use of services and the reasons for member disenrollment. It is agreed that the standards by which the CCN will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the CCN must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. DHH must prior approve the CAP and will monitor the CCN's progress in correcting the deficiencies. See *CCN Policy and Procedure*.

In the event the CCN fails to complete the actions required by the CAP, the CCN agrees that DHH will assess the monetary penalties specified in **§13.3.1** of this Provider Agreement. The CCN further agrees that any monetary penalties assessed by DHH will be due and payable to DHH immediately upon notice. If payment is not made by the due date, said monetary penalties may be withheld from future enhanced primary care case management fee payments by DHH without further notice.

The CCN is required to conduct performance improvement projects as specified in the *CCN-S Policy and Procedure Guide*.

4.7.1 Performance Measures

The CCN is required to collect and report clinical and administrative quality performance measure (PM) data, as specified by DHH and in accordance with the *Quality Companion Guide*. Performance measure data shall be submitted to DHH quarterly, annually, and upon DHH request. The data shall demonstrate adherence to clinical practice guidelines and/or improvement in patient outcomes. The CCN shall have processes in place to monitor and self-report all PMs. DHH will monitor the CCN's performance using Benchmark Performance and Improvement Performance data.

Starting year 2 of the measurement year, or as otherwise specified by DHH, a maximum of 100% of eligible savings (10% for each of 10 specified Performance Measures) will be assessed for those specified performance measures that fall below DHH's performance benchmarks. Performance measures that fall below performance standards will require a corrective action plan (CAP).

4.7.1.1 Early Warning System Performance Measures

The CCN shall collect and report administrative performance measures data, as specified by DHH in this Provider Agreement and in the CCN-S Policies and Procedures Guide, in order to monitor and evaluate the successful implementation of the CCN program. During the first year of implementation, the CCN shall also report those measures specified in Appendix C on a monthly basis to DHH.

4.7.2 Performance Improvement Projects

The CCN is required to conduct Performance Improvement Projects (PIP). DHH may specify performance measure(s) and topics for performance improvement projects in addition to CCN chosen PIPs as specified in the *CCN-S Policy and Procedure Guide*. The CCN shall report the status and results of each PIP as specified in the *CCN-S Policy and Procedure Guide*. The CCN's PIPs shall be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. Each PIP must involve the following:

- 4.7.2.1 Measurement of performance using objective quality indicators;
- 4.7.2.2 Implementation of system interventions to achieve improvement in quality;
- 4.7.2.3 Evaluation of the effectiveness of the interventions; and
- 4.7.2.4 Planning and initiation of activities for increasing or sustaining improvement.

PIPs must be completed in a reasonable time period so as to generally allow information on the success of the PIPs in the aggregate to produce new information on quality of care every year.

4.8 **Nurse Advice Line**

The CCN members may utilize the Medicaid URAC certified Nurse Triage and Education line available to all Medicaid eligibles at no cost or, contingent upon DHH approval, the CCN may market its own nurse advice line.

4.9 **Coordination of Medicaid State Plan Services**

The CCN shall be required to provide service authorization, refer, coordinate, and/or provide assistance in scheduling medically necessary services consistent with the standards as defined in the Title XIX Louisiana State Medicaid Plan and the *CCN-S Policy and Procedure Guide* regarding service limits and service authorization requirements with the exception of physician visits. The CCN may have policies and processes to authorize physician visits in excess of the 12 visit limit for adults specified in the State Plan, when it is cost effective to do so. These services will be paid on a FFS basis by DHH's fiscal intermediary.

A summary listing of the Medicaid State Plan services is as follows:

- Inpatient Hospital Services
- Outpatient Services
- Ancillary Medical Services
- Organ Transplant and Related Services
- EPSDT/Well Child Visits
- Emergency Medical Services
- Communicable Disease Services
- Durable Medical Equipment
- Home Health Services
- Family Planning Services
- Basic Behavioral Health Services
- School-Based Health Clinic Services

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- Physician Services
- Maternity Services
- Chiropractic Services
- Therapy Services (physical, occupational, and speech therapies)
- Women, Infants and Children (WIC) Referrals

The CCN will be responsible to coordinate those services that by statute must be provided and are medically necessary. Claims will be paid FFS by State's FI. The CCN shall not implement hard limits/caps for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

The CCN will not be responsible to pre-process or provide service authorization, but shall provide any required referrals and coordination, for the following services:

- a. Services provided through DHH's Early Step Services (IDEA Part C Program Services)
- b. Dental Services
- c. Personal Care Services (EPSDT and LT-PCS)
- d. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Services
- e. Home & Community-Based Waiver Services
- f. Hospice Services
- g. Non-Emergency and Emergency Transportation
- h. School-based Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district, Nursing Facility Services
- i. Pharmacy
- j. Specialized Behavioral Health Services
- k. Targeted Case Management

4.9.1 Care Coordination for Special Populations

The CCN shall implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. The CCN shall have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

The CCN shall identify members with special health care needs within ninety-(90) days of receiving the member's historical claims data (if available). However, during the phase-in implementation of the CCN

Program, DHH will extend this requirement to one hundred and eighty (180) days from the enrollment effective date. The CCN shall adhere to the assessment and reporting requirements set forth in the *CCN-S Policy and Procedure Guide*.

4.9.2 Behavioral Health Services

The CCN shall strongly support the integration of both physical and behavioral health services through screening and strengthening prevention/early intervention at the PCP level of care. The PCP shall collaborate with behavioral health specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, or licensed professional counselors either in mental health clinics, mental health rehabilitation service providers (public or private), and other specialty behavioral health providers, to ensure the provision of services to members as specified in the Medicaid State Plan.

4.9.2.1 For the purposes of this Provider Agreement, behavioral health services shall be divided into two levels:

4.9.2.1.1 Basic behavioral health services shall include, but not be limited to, screening, prevention, early intervention, medication management, and referral services as defined in the Medicaid State Plan; and

4.9.2.1.2 Specialized behavioral health services shall include, but not be limited to, services specifically defined in state plan and provider by psychiatrists, psychologists, and/or mental health rehabilitation providers to those members with a primary diagnosis of a mental and/or behavioral disorder.

4.9.2.2 Basic Behavioral Health Services

The CCN shall be responsible for ensuring the provision of basic behavioral health benefits and services to all members. The CCN PCPs shall utilize the screening tools and protocols approved by DHH. See the *CCN-S Policy and Procedure Guide* for basic behavioral health services/benefits included.

4.9.3 Emergency Services

The CCN shall insure that emergency and post-stabilization services be rendered without the requirement of prior authorization of any kind; and

shall advise all CCN members of the provisions governing the use of emergency services. The CCN shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The CCN shall submit for prior approval by DHH, a copy of its written emergency services definitions and any protocols.

The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the State and CCN identified in 42 CFR §438.114(b) as responsible for coverage and payment.

4.10 Manner of Service Delivery and Provision

In establishing and maintaining the PCP network, the CCN shall consider the following:

- a. The maximum Medicaid/CHIP enrollment capacity;
- b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid/CHIP populations enrolled in the CCN;
- c. The number of network providers who are not accepting new Medicaid/CHIP patients; and
- d. The geographic location of providers and Medicaid/CHIP members; considering distance travel time, and means of transportation ordinarily used by Medicaid/CHIP members.
- e. All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid/CHIP members with disabilities.

The CCN shall allow female members direct access to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventive health care services. This is in addition to the members designated source of primary care if that source is not a women’s health specialist.

4.11 Patient-Centered Medical Home

The CCN will promote and facilitate the capacity of all PCP practices to meet the recognition requirements of a NCQA PPC®-PCMH™ as jointly defined by NCQA and DHH.

The CCN shall report those primary care provider practices that achieve recognition or meet the requirements of the National Committee for Quality Assurance (NCQA) for PPC®-PCMH™. The CCN shall ensure thresholds and timetables are met for the establishment of PCP practice NCQA PPC®-PCMH™ recognition, Levels 1-3, and as defined in the *CCN-S Policy and Procedure Guide* and the terms and conditions of this Provider Agreement

4.12 Designated Service Area

A designated service area is defined as the geographic area a CCN has been approved to provide enhanced primary care case management services under this Provider Agreement. The minimum designated service area in which DHH will enter into Provider Agreement with a CCN is an entire parish. The CCN's service area may consist of multiple parishes and/or multiple DHH Administrative Regions (See *CCN-S Policy and Procedure Guide*). DHH will enter into one Provider Agreement regardless of the number of service areas. Preference will be given in the automatic assignment process to CCNs whose service area includes all parishes within the region.

The initial implementation of Coordinated Care Networks will be phased in based on DHH's administrative regions. When submitting a Provider Agreement the CCN must complete the CCN Enrollment Process by DHH's deadline to ensure first market entry. The CCN shall be required to amend their existing Provider Agreement to add service areas for subsequent Phases of implementation.

The CCN shall submit a document describing its designated service area, in the format specified in the *CCN-S Policy and Procedure Guide*. The document shall be incorporated herein as part of the Provider Agreement. Any changes to the CCN's designated service area must be approved by DHH sixty (60) calendar days prior to the effective date of the proposed change.

4.13 Adequacy of Providers

The CCN shall maintain appropriate levels of primary care providers for the provision of services under this Provider Agreement to ensure adequate accessibility for CCN members.

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The CCN shall also make available and accessible, as determined by DHH, professional personnel sufficient to provide the required enhanced primary care case management services.

The locations of primary care providers must be sufficient in terms of geographic convenience to Medicaid/CHIP enrollees.

DHH detailed standards, criteria and requirements for CCN submissions and ongoing review of provider adequacy are located in the *CCN-S Policy and Procedure Guide*.

The CCN shall notify DHH immediately of any changes to the composition of its provider network and/or contractors that materially and/or adversely affects its ability to make available all primary care services and care management services in a timely manner in accordance with § 4.14 of this Provider Agreement. The CCN shall have procedures to address changes in its provider network that negatively affect the ability of CCN members to access services. Material changes in provider network composition that are not prior approved by DHH and/or that may impair the CCN member's access to services will be considered as grounds for Provider Agreement sanctions, including but not limited to, termination. The CCN understands and agrees that notwithstanding the execution of this Provider Agreement, neither the CCN nor its contractor/network provider shall provide any services to a CCN member until the CCN has an adequate provider network verified and approved by DHH. Enrollees must receive written notice within thirty (30) days of any material change in provider network before the intended effective date of the change.

In the event a CCN is found to be in violation of the requirements stated in this section, DHH reserves the right to implement the CCN Provider 120 Day Transition Plan or other sanctions, as described in the *CCN-S Policy and Procedure Guide*.

DHH may also, at its sole discretion, suspend any new enrollments in the CCN, including auto-enrollments, in the affected parish(es) during the Transition Plan period or until the CCN has demonstrated that it will be able to maintain its services in their designated service area(s).

4.13.1 CCN's Provider Network Composition

The CCN shall not discriminate against the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. The CCN shall not discriminate against the participation, reimbursement, or indemnification of any

provider who serves high-risk populations or specializes in conditions that require costly treatment. If the CCN declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

The CCN must maintain and monitor a primary care provider network that is supported by written agreements and is sufficient to provide timely and adequate access. When designing this network, the CCN must take into consideration all the requirements specified in the Provider Agreement's terms and conditions. This includes, but is not limited to, access standards and guidelines for delivery of primary care services; and referrals and coordination to specialists and hospitals. The CCN network providers shall comply with all requirements set forth in this Provider Agreement and the *CCN-S Policy and Procedure Guide*.

4.13.2 Primary Care Providers (PCP)

A PCP in the CCN must be a provider who provides or arranges for the delivery of medical services, including care coordination, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in § 4.14 of this Provider Agreement. The PCP may practice in a solo or group setting or may practice in a clinic (i.e., Federally Qualified Health Center or Rural Health Clinic) or outpatient clinic. The CCN shall agree to provide at least one (1) full-time equivalent (FTE) PCP per two thousand (2,000) CCN members. The CCN shall ensure each individual PCP shall not exceed a linkage total of 2,000 Medicaid/CHIP eligibles (including CommunityCARE) across all CCN's in which the PCP may be a network provider and a DHH CommunityCARE program provider.

Each Medicaid/CHIP potential enrollee shall be given the opportunity to choose between CCNs, and to choose a specific PCP within the CCN's provider network, that will be responsible for the provision of primary care services and the coordination of all other health care needs. Medicaid/CHIP eligibles that are unable or unwilling to make a choice of CCN at the point of completing the Medicaid or CHIP application form shall be contacted by DHH's Enrollment Broker to assist the individual in choosing a CCN. The Enrollment Broker shall assign a CCN to a Medicaid/CHIP potential enrollee/enrollee if the potential enrollee/enrollee fails to select a CCN within the established timeframe or after a change in CCN has occurred (i.e. CCN no longer participating).

The PCP selected for the CCN member should be a provider that is located geographically close to the CCN member's home, and/or best

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meets the needs of the member. However, the CCN member has the freedom to request a change of primary care provider within the CCN anytime with cause.

The CCN shall identify and report to the Enrollment Broker within seven (7) calendar days any PCP approved to provide services under this Provider Agreement who will not accept new patients or has reached capacity.

The PCP shall serve as the member's initial and most important point of interaction.. The PCP responsibilities shall include, but not be limited to:

- 4.13.2.1** Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;
- 4.13.2.2** Monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment;
- 4.13.2.3** Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through fee-for-service Medicaid;
- 4.13.2.4** Maintaining a medical record of all services rendered by the PCP and other referral providers.
- 4.13.2.5** Providing for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions;
- 4.13.2.6** Providing case management services to include, but not be limited to, screening and assessment, development of a treatment plan of care to address risks and medical needs and other responsibilities as defined in the *CCN-S Policy and Procedure Guide*;
- 4.13.2.7** Prohibiting discrimination in enrollment, disenrollment, and re-enrollment, based on the recipient's health status or need for health care services.

4.14 Service Accessibility Standards

The CCN shall assist DHH in providing primary care access to all CCN members for Medicaid State Plan health care services through referral and coordination of such services in accordance with the *CCN-S Policy and Procedure Guide*. As it relates to primary care services, the CCN shall ensure the following:

4.14.1 Travel Time and Distance

The CCN shall ensure that in accordance with usual and customary practices primary care provider services are available on a timely basis.

4.14.1.1 Access to Primary Care Providers

4.14.1.1.1 Travel distance for members living in rural parishes shall not exceed 30 miles; and

4.14.1.1.2 Travel distance for members living in urban parishes shall not exceed 20 miles.

Services are considered accessible if they reflect usual practice and travel arrangements in the local area. Exceptions may be approved if the travel distance for medical care exceeds these requirements.

4.14.2 Scheduling/Appointment Waiting Times

The CCN shall ensure that its network providers have an appointment system for primary care services which are in accordance with prevailing medical community standards as specified below.

The CCN's network providers/contractors shall not use discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay patients.

4.14.2.1 Timely Access

The CCN shall ensure that medically necessary services are available on a timely basis, as follows:

- a. Emergent or emergency visits immediately upon presentation at the service delivery site;
- b. Urgent Care within twenty-four (24) hours;

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- c. Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;
- d. Maternity Care:
 - 1. Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the CCN mails the member's welcome packet:
 - 2. Within their first trimester within fourteen (14) days;
 - 3. Within the second trimester with seven (7) days;
 - 4. Within their third trimester with three (3) days;
 - 5. High risk pregnancies within three (3) days of identification of high risk by the CCN or maternity care provider, or immediately if an emergency exists;
 - 6. Initial appointment for CCN members who become pregnant shall be within forty-two (42) days;
- e. Routine, non-urgent, or preventative care visits within six (6) weeks;
- f. Specialty care consultation within one (1) month of referral or as clinically indicated;
- g. Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated; and
- h. Follow-up visits in accordance with ER attending provider discharge instructions.

4.15 Cultural Considerations

The CCN shall promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

The CCN shall have written procedures for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, members with limited English Proficiency at no cost to the member. The provision for any needed interpretation services shall be the responsibility of the CCN.

4.16 Immunization Data

The CCN and its network providers shall utilize DHH’s Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations.

4.17 Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/ Well Child Visits

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is a comprehensive and preventative child health program for individuals under the age of 21. The EPSDT statute and federal Medicaid regulations require that states cover all services within the scope of the federal Medicaid program, including services outside the Medicaid State Plan, if necessary to correct or ameliorate a known medical condition. 42 U.S.C. §1396d(r)(5). The program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required healthcare services; and (2) helping Medicaid members and their parents or guardians effectively use these resources. The intent of the EPSDT program is to direct attention to the importance of preventive health services and early detection and treatment of identified problems.

The CCN shall have written procedures for EPSDT services in compliance with 42CFR §441.50, Subpart B-Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), as well as be in compliance with the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual, Part 5 – EPSDT for notification, tracking, and follow-up to ensure these services will be available to all eligible Medicaid CCN Program children and young adults. These articles outline the requirements for EPSDT, including assurance that: all EPSDT eligible members are notified of EPSDT available services; necessary screening, diagnostic, and treatment services are available and provided; and tracking or follow-up occurs to ensure all necessary services were provided to all of the CCN’s eligible Medicaid children and young adults. The requirements for provision of EPSDT services are outlined in the *CCN-S Policy and Procedure Guide*.

The CCN shall assure that all medically necessary diagnosis, treatment and screenings services are provided, either directly, through contracting, or by referral. The utilization of these services shall be reported as referenced in the *CCN-S Policy and Procedure Guide*. The CCN's providers shall also report the required immunization data into the Louisiana Immunization Information System (LINKS) administered by the DHH/Office of Public Health.

4.18 FQHC/RHC Clinic Services

The CCN shall make a good faith effort to execute a contract with Federally Qualified Health Centers (FQHC), and, where applicable, Rural Health Clinics (RHC). In the event an agreement cannot be reached and an entity does not participate in the CCN, the CCN shall maintain documentation detailing efforts which were made.

If an agreement cannot be reached with a FQHC/RHC, the CCN is not required to provide service authorization except in the following cases:

- 4.18.1 The medically necessary services are required to treat an emergency medical condition;
- 4.18.2 If there are no CCNs in a service area that provide in-network access to FQHCs, then all CCNs within the service area would be required to provide authorization for medically necessary out-of-network services as specified in the Provider Agreement; and
- 4.18.3 DHH has chosen to recognize FQHCs that are certified Office of Public Health school-based health clinics (SBHC), therefore, whether the FQHC/SBHC is within their network or not, the CCN shall authorize all medically necessary Medicaid State Plan services provided in the FQHC/SBHC "school setting". However, if the child had a separate visit to the FQHC/SBHC outside the "school setting, the CCN could deny authorization of that visit as out-of-network.

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5 NETWORK PROVIDER CONTRACT REQUIREMENTS

The CCN shall authorize the provision of all primary care services and provide enhanced care management services specified in §4 of this Provider Agreement. The CCN may authorize these services directly or may enter into contracts with entities who will authorize services and provide care management to the members. The provision of Medicaid health care services will be delivered by the Louisiana Medicaid provider network. Claims will be pre-processed by the CCN and paid by the State's FI. The CCN is ultimately responsible for all requirements of this Provider Agreement, including those performed by the CCN contractor(s). Any plan to delegate responsibilities of the CCN to a contractor shall be approved by DHH and a copy all model contracts shall be submitted to DHH for approval prior to execution. The CCN must follow all the terms and conditions of the Provider Agreement entered into with DHH concerning its relationships with its network providers. These terms and conditions include, but are not limited to, care management incentive and reimbursement methodologies, care management, quality assurance, and health information technology.

Model contracts for care management providers shall be submitted during the CCN Enrollment Process and shall specify that the contractor adhere to the Quality Assessment and Performance Improvement (QAPI) requirements specified by DHH in this Provider Agreement, *CCN-S Policy and Procedure Guide*, and *Quality Performance Measure Companion Guide*. After the execution of this Provider Agreement, the CCN shall submit to DHH for review and approval, prior to execution of the contract, any contract that is materially different from the model contract already approved by DHH for care management providers. DHH shall have the right to review and approve any and all contracts entered into for the provision of any activities under this Provider Agreement. The turnaround time for approval is expected to be thirty (30) days or less.

Notification of amendments or changes to any contract which, in accordance with §3.4 of this Provider Agreement, materially affects this Provider Agreement, shall be provided to DHH prior to the execution of the amendment in accordance with §1.7 of this Provider Agreement. The CCN shall not execute contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The CCN shall not enter into any relationship (See *Appendix A – Definition of Terms*) with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

In the event of non-renewal of a contractor's agreement, the CCN shall inform DHH of the intent to terminate any contract that may materially impact the provider's network

and/or operations as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination of said contract.

If the CCN terminates a provider's contract for cause, the CCN shall provide immediate notice to the provider. The CCN shall notify DHH of their termination as soon as possible, but no later than seven (7) calendar days of written notification of cancellation to the provider.

If termination is related to network access, the CCN shall notify DHH. The notification shall include their plans to notify members of such change and strategy to ensure timely access to members. If termination is related to the CCN's operations, the notification shall include the CCN's plan of how it will ensure there will be no stoppage or interruption of services to members or providers.

The CCN must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each CCN member who received their primary care from or was seen on a regular basis by the terminated provider.

5.1 Network Provider Contract Requirements

All contracts executed by the CCN pursuant to this section shall, at a minimum, include the requirements listed below which are also in force for this Provider Agreement between DHH and CCN. All contracts must:

- 5.1.1 Be in writing and signed by the CCN and the contractor;
- 5.1.2 Specify the effective dates of the contract;
- 5.1.3 Specify in the contract that the contract and its appendices contain all the terms and conditions agreed upon by the parties;
- 5.1.4 Require that no modification or change of any provision of the contract shall be made unless such modification is incorporated and attached as a written amendment to the contract and signed by the parties, however, the CCN may provide amendments by written notification through a CCN bulletin if mutually agreed to in terms of the contract and with prior notice to DHH;
- 5.1.5 Assure that the contractor shall not enter into any subsequent agreements or contracts for any of the work contemplated under the contract without approval of the CCN;
- 5.1.6 Specify that the services provided under the contract must be in accordance with the Louisiana Medicaid State Plan and require that the

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contractor shall provide these services to members through the last day that the contract is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee;

- 5.1.7** Specify that the contractor may not refuse to provide medically necessary or covered preventive services to CCN members specified under this Provider Agreement for non-medical reasons (except those services allowable under federal law for religious or moral objections);
- 5.1.8** Require that the contractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the contract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the CCN;
- 5.1.9** Specify the amount, duration and scope of care management and authorization of services to be provided by the contractor;
- 5.1.10** Provide that emergency services be rendered without the requirement of prior authorization of any kind;
- 5.1.11** Require that an adequate record system be maintained for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to members pursuant to the contract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Provider Agreement). CCN members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 1643524 as amended and subject to reasonable charges;
- 5.1.12** Require that any and all member records including but not limited to administrative, financial, medical be retained (whether electronic or paper) for a period of six (6) years after the last payment was made for services provided to a member and retained further if the records are under review, audit, or related to any matter in litigation until the review, audit, or litigation is complete. This requirement pertains to the retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. Current State law (LRS 40:1299.96) requires physicians to retain their records for at least six (6) years. These minimum record keeping periods begin to run from the last date of treatment. After these minimum record-keeping periods, state law allows for the destruction of records. Said records shall be

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made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHH;

- 5.1.13 Provide that DHH, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Legislative Auditor's Office, and the Louisiana Attorney General's Office shall have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Provider Agreement, including quality, appropriateness and timeliness of services and the timeliness and accuracy of claims submitted to the CCN. Such evaluation, when performed, shall be performed with the cooperation of the CCN. Upon request, the CCN shall assist in such reviews;
- 5.1.14 Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the CCN and/or DHH or its designee;
- 5.1.15 Specify that the contractor shall monitor and report the quality of services delivered under the contract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the contractor practices and/or the performance standards established by DHH in this Provider Agreement and *CCN-S Policy and Procedure Guide*;
- 5.1.16 Require that the contractor comply with any plan of correction initiated by the CCN and/or required by DHH;
- 5.1.17 Provide for submission of all reports and clinical information required by the CCN and/or DHH in this Provider Agreement, including but not limited to, HEDIS, AHRQ;
- 5.1.18 Require safeguarding of information about CCN members according to applicable state and federal laws and regulations and as described in **§14** of this Provider Agreement;
- 5.1.19 Provide the name and address of the official payee to whom payment (e.g. monthly care management fee and shared savings, if applicable) shall be made in accordance with federal regulation;
- 5.1.20 Make full disclosure of the method and amount of compensation or other consideration to be received from the CCN;

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- 5.1.21** Provide for prompt submission of information needed to make payment and/or for completion of DHH required reports;
- 5.1.22** Specify that at all times during the term of the agreement, the contractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Provider Agreement between DHH and the CCN, unless the contractor is a state agency. For contractors that are not state agencies, the indemnification may be accomplished by incorporating **§14.22** of this Provider Agreement in its entirety in the contractor’s contract or by use of other language developed by the CCN and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.
- 5.1.23** Require the contractor to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CCN’s members and the CCN under the agreement. The contractor shall provide such insurance coverage at all times during the agreement and must be maintained during the life of the contract, including all renewal/extension periods and upon execution of the contract agreement, shall furnish CCN with written verification of the existence of such coverage;
- 5.1.24** Specify that the contractor agrees to recognize and abide by all state and federal laws, Medicaid State Plan, rules and regulations and guidelines applicable to the provision of services under the Coordinated Care Program;
- 5.1.25** Provide that the contract incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into the agreement as they become effective. In the event that changes in the contract as a result of revisions and applicable federal or state law that materially affect the position of either party, the CCN and contractor agree to negotiate such further amendments as may be necessary to correct any inequities;
- 5.1.26** Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the agreement termination date, or early termination of the contract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the agreement, however, the CCN may provide amendments by written notification through CCN bulletin if mutually agreed to in terms of the contract and with prior notice to DHH;

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- 5.1.27 Specify that the CCN and contractor recognize that in the event of termination of this Provider Agreement between the CCN and DHH for any of the reasons described in this Provider Agreement, the CCN shall immediately make available, to DHH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the CCN's and contractor's activities undertaken pursuant to the contractor agreement. The provision of such records shall be at no expense to DHH;
- 5.1.28 In the event the CCN terminates its contract with DHH, it must allow its network providers to terminate their contract with the CCN, in accordance with the terms of their contract;
- 5.1.29 Provide that the CCN and contractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the CCN member;
- 5.1.30 Include a conflict of interest clause as stated in §14.29 of this Provider Agreement between the CCN and DHH;
- 5.1.31 Specify that the contractor must adhere to the Quality Assessment Performance Improvement and Utilization Management (UM) requirements as outlined in this Provider Agreement and *CCN-S Policy and Procedure Guide*.
- 5.1.32 Provide that all contractors shall give the CCN immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the CCN's ability to perform under this Provider Agreement with DHH. The CCN shall assure that all responsibilities related to the contract are performed in accordance with the terms of this Provider Agreement;
- 5.1.33 Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary health care services;
- 5.1.34 Specify that the contractor shall not assign any of its duties and/or responsibilities under this Provider Agreement without the prior written consent of the CCN;
- 5.1.35 Specify that the CCN shall not prohibit or otherwise restrict a network provider/ contractor from advising a member about the health status of the member or medical care or treatment for the member's condition or disease, regardless of whether benefits for such care or treatment are

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provided under this Provider Agreement, if the network provider/contractor is acting within the lawful scope of practice.

- 5.1.36** Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the contractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement;
- 5.1.37** Contains no provision which restricts a network provider/ contractor from contracting with another CCN or other managed care entity or directly with the Louisiana Medicaid Program;
- 5.1.38** Provide that all records originated or prepared in connection with the contractor's performance of its obligations under contract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the contractor in accordance with the terms and conditions of this Provider Agreement. The contract must further provide that the contractor agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under this Provider Agreement, and as further required by DHH, for a period of six (6) years from the expiration date of the Provider Agreement, including any Provider Agreement extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If the contractor stores records on microfilm or microfiche or other electronic means, the contractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within twenty-one (21) calendar days of the request;
- 5.1.39** The Medicaid/CHIP enrollee may not be held liable for payment for authorized services furnished under a provider agreement, referral or other arrangement to the extent that those payments are in excess of the amount paid by Medicaid;
- 5.1.40** Restrict enrollment to enrollees who reside sufficiently near one of the PCP delivery sites so as to reach that site within a reasonable time using available and affordable modes of transportation;

- 5.1.41** Provide that contractors must submit all claims for payment no later than twelve (12) months from the date of service. EPSDT screening claims should be submitted within sixty (60) days from date of service to accommodate for frequency of screening services and for EPSDT reporting requirements. EPSDT screening claims must also include information related to immunizations, referrals and health status as published in the EPSDT Services Rule (*Louisiana Register, Vol 30, No. 8*);
- 5.1.43** Provide that PCP's contract specify the maximum number of linkages the CCN may link to the PCP. The contract shall also stipulate that by signing the contract, the PCP confirms that the total number of linkages the PCP specifies to the CCN, along with any and all linkages, the PCP may have through CommunityCARE and with other CCN's in which they are enrolled, will **NOT** exceed 2,000 Medicaid lives. The contract may also include language that non-compliance with this provision may result in sanctions, including but not limited to, financial sanctions, transfer of members to another PCP within the CCN, and/or termination of the contract.
- 5.1.44** Contain language that the contractor shall adhere to all requirements set forth for CCN network providers in the Provider Agreement and *CCN-P Policy and Procedure Guide*; and either physically incorporating these document as appendices to the contract or include language in the contract the CCN shall furnished these documents to the provider upon request.

5.2 Subcontractor Requirements

The CCN must oversee and be accountable for any functions and responsibilities that it delegates to any subcontractor, including:

- 5.2.1** All subcontracts must fulfill the requirements of 42 CFR § 438 that are appropriate to the service or activity delegated under the subcontract.
- 5.2.2** Each CCN must ensure that the entity evaluates the prospective subcontractor's ability to perform the activities to be delegated.
- 5.2.3** The CCN must require a written agreement between the entity and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or

imposing other sanctions if the subcontractor's performance is inadequate.

5.2.4 The CCN must ensure that the entity monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards.

5.2.5 The CCN must ensure that the entity identifies deficiencies or areas for improvement, the entity and the subcontractor must take corrective action.

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6 EDUCATION, SELECTION AND ENROLLMENT PROCESS

DHH determines eligibility for Medicaid for all coverage groups except for Supplemental Security Income (SSI), Family Independence Temporary Assistance Program (FITAP), and Foster Care. The Social Security Administration (SSA) determines eligibility for SSI and the Department of Social Services (DSS) determines eligibility for FITAP and Foster Care. Once an applicant is determined eligible for Medicaid by DHH, DSS, or SSA, the pertinent eligibility information is entered in the Medicaid Eligibility Determination System (MEDS).

DHH contracts with an Enrollment Broker for the CCN Program enrollment and disenrollment process for all Medicaid/CHIP eligibles whose enrollment in a CCN is mandatory or voluntary. The Enrollment Broker shall be the primary contact for Medicaid/CHIP eligibles concerning the selection of Coordinated Care Networks and shall assist the potential enrollee to become a member of a CCN. The Enrollment Broker shall be the **only authorized** entity other than DHH, to assist a Medicaid/CHIP eligibles in any manner in the selection of a CCN and shall be responsible for notifying all CCN members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in this section. The rights afforded to potential CCN members are detailed in the *CCN-S Policy and Procedure Guide, Member's Bill of Rights*.

The CCN shall abide by all enrollment and disenrollment procedures as outlined in the *CCN-S Policy and Procedure Guide*.

In accordance with 42 CFR §438.10(b)(1), the Enrollment Broker and CCN shall provide all enrollment notices, informational materials and processes, and instructional materials relating to enrollees and potential enrollees in a manner and format that are in a style and reading level that will accommodate the reading skills of CCN Enrollees. In general the writing should be at no higher than a 6.9 grade level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. The text must be printed in at least ten-point font, preferably twelve-point font. Alternative formats must be available that take into consideration the special needs of those who, for example, are visually limited or have limited English proficiency.

The CCN agrees it shall have the statewide capacity to enroll a minimum number of fifteen thousand (15,000) Medicaid/CHIP enrollees.

6.1 Enrollment Population

6.1.1 **Mandatory Populations**

Individuals eligible for Medicaid or CHIP who are mandated to participate in a Coordinated Care Network (CCN) include:

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- **Children** under 19 years of age including those who are eligible under Section 1931 poverty-level related groups and optional groups of older children in the following categories:
 - **LIFC Program** (Low Income Families with Children) - Individuals and families who meet the eligibility requirements of the AFDC State Plan in effect on July 16, 1996;
 - **FITAP Program** (Families in Temporary Need of Assistance) - Individuals and families receiving cash assistance through the state's Temporary Assistance to Needy Families (TANF) Program administered by the DSS;
 - **CHAMP-Child Program** - Children up to age 19, who meet financial and non-financial eligibility criteria. Deprivation or uninsured status is not an eligibility requirement;
 - **Deemed Eligible Child Program** - Infants born to Medicaid eligible pregnant women, regardless of whether or not the infant remains with the birth mother, throughout the infant's first year of life;
 - **Youth Aging Out of Foster Care** - Children under age 21 who were in foster care (and already covered by Medicaid) on their 18th birthday, but have aged out of foster care;
 - **Continued Medicaid Program** - Short-term coverage for families who lose LIFC or TANF eligibility because of child support collections, an increase in earnings, or an increase in the hours of employment; and
 - **Regular Medically Needy Program** - Individuals and families who have more income than is allowed for regular on-going Medicaid.
- **LaCHIP Program** - Children enrolled in the Title XXI Medicaid expansion program for low-income children under age 19 who do not otherwise qualify for Medicaid, including LaCHIP Phases I, II, and III.

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- **Parents** eligible under Section 1931 and optional caretaker relative groups including:
 - LIFC Program
 - FITAP Program
 - Continued Medicaid Program
 - Regular Medically Needy Program
- **Pregnant Women** - Individuals whose basis of eligibility is pregnancy, who are eligible for pregnancy related services including:
 - **LaMOMS (CHAMP-Pregnant Women)** - Pregnant women who receive coverage for prenatal care, delivery, and care sixty (60) days after delivery and
 - **LaCHIP Phase IV Program** - Non-citizen, uninsured pregnant women who receive prenatal care (from conception to birth) services.
- **Breast and Cervical Cancer (BCC) Program** - Uninsured women under age 65 who are not otherwise eligible for Medicaid and are identified through the Centers for Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer.
- **Aged, Blind & Disabled Adults** - Individuals, 19 or older, who do not meet any of the conditions for exclusion from participation in a CCN, including:
 - **Supplemental Security Income (SSI) Program** - Individuals 19 and older who receive cash payments under Title XVI (Supplemental Security Income) administered by the Social Security Administration and
 - **Extended Medicaid Programs** - Certain individuals who lose SSI eligibility because of a Social Security cost of living adjustment (COLA) or in some cases entitlement to

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or an increase in Retirement, Survivors, Disability Insurance (RSDI) benefits, i.e., Social Security benefits. SSI income standards are used in combination with budgeting rules which allow the exclusion of cost of living adjustments and/or certain benefits. Extended Medicaid consists of the following programs:

- **Disabled Adult Children** - Individuals over 18 who become blind or disabled before age 22 and lost SSI eligibility on or before July 1, 1987, as a result of entitlement to or increase in RSDI Child Insurance Benefits;
- **Disabled Widows/Widowers** - Disabled widows/widowers who would be eligible for SSI had there been no elimination of the reduction factor and no subsequent COLAs;
- **Early Widows/Widowers** - Individuals who lose SSI eligibility because of receipt of RSDI early widow/widowers benefits;
- **Pickle** - Aged, blind, and disabled persons who become ineligible for SSI or MSS as the result of cost of living increase in RSDI or receipt and/or increase of other income including:
 - **Group One** - Individuals who concurrently received and were eligible to receive both SSI and RSDI in at least one month since April 1, 1977, and lost SSI as the direct result of an RSDI COLA and
 - **Group Two** - Individuals who were concurrently eligible for and received both SSI and RSDI in at least one month since April 1, 1977, and lost SSI due to receipt and/or increase of income other than an RSDI COLA, and would again be eligible for SSI except for COLAs received since the loss of SSI;

- **Disabled Widows/Widowers and Disabled Surviving Divorced Spouses Unable To Perform Any Substantial Gainful Activity-** Widow/widowers who are not entitled to Part A Medicare who become ineligible for SSI due to receipt of SSA Disabled Widow/widowers Benefits so long as they were receiving SSI for the month prior to the month they began receiving RSDI, and they would continue to be eligible for SSI if the amount of the RSDI benefit were not counted as income;
- **Blood Product Litigation Program** - Individuals who lose SSI eligibility because of settlement payments under the Susan Walker v. Bayer Corporation settlement and the Ricky Ray Hemophilia Relief Fund Act of 1998;
- **Medicaid Purchase Plan Program** - Working individuals between ages 16 and 65 who have a disability that meets Social Security standards; and
- **Disability Medicaid Program** - Disabled and aged (65 or older) individuals who meet all eligibility requirements of the SSI program without first having a SSI determination made by the Social Security Administration.

6.1.2 Voluntary Populations

In accordance with 42 CFR § 438.6(d)(2), participation in a CCN is voluntary for individuals in the SSI/Disability populations (**children under the age of 19 only**). After a choice period, SSI/disability Medicaid/CHIP eligibles will be enrolled in a CCN if they have not made a choice.

6.1.2.1 The following populations are also voluntary under the State’s 1932 SPA and after a choice period of fifteen (15) days if they do not choose a plan, they will be enrolled in a CCN, but may request disenrollment at any time without cause, effective the first day following the month of the request for disenrollment including:

- 6.1.2.1.1** Native Americans who are members of federally recognized tribes, except when the CCN is:
- a. The Indian Health Service; or
 - b. An Indian health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

6.1.2.1.2 Children under 19 years of age who are:

- a. Eligible for SSI under title XVI;
- b. Eligible under section 1902(e)(3) of the Act;
- c. In foster care or other out-of-home placement;
- d. Receiving foster care or adoption assistance;
- e. Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the DHH in terms of either program participation or special health care needs; or
- f. Enrolled in the Family Opportunity Act Medicaid Buy-In Program.

Enrollees may request an additional fifteen (15) day extension to the choice period if the request is made to the Enrollment Broker prior to the fifteenth (15th) day. The Enrollment Broker will ensure that all voluntary populations will be notified at the time of enrollment of their ability to opt out at any time without stating a cause.

6.1.3 Excluded Populations

Individuals eligible for Medicaid who cannot voluntarily enroll with a CCN including:

- Individuals receiving hospice services;
- Individuals Residing in Nursing Facilities (NF) or Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
- Individuals with Medicare(dual eligibles):
- Individuals who have been diagnosed with tuberculosis, or suspected of having tuberculosis, and receiving tuberculosis-related services through the Tuberculosis Infected Individual Program;
- Individuals receiving services through any 1915(c) Home and Community-Based Waiver including, but not limited to:
 - **Adult Day Health Care (ADHC)** - Direct care in a licensed adult day health care facility for those individuals who would otherwise require nursing facility services;

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- **New Opportunities Waiver (NOW)** - Individuals who would otherwise require ICF/DD services;
- **Elderly and Disabled Adult (EDA)** - Services to persons aged 65 and older or disabled adults who would otherwise require nursing facility services;
- **Children’s Choice (CC)** - Supplemental support services to disabled children under age 18 on the NOW waiver registry;
- **Residential Options Waiver (ROW)** - Individuals living in the community who would otherwise require ICF/DD services;
- **Supports Waiver** - Individuals 18 years and older with mental retardation or a developmental disability which manifested prior to age 22; and
- **Other HCBS waivers as may be approved by CMS.**
- Individuals under the age of 21 otherwise eligible for Medicaid who are listed on the Office for Citizens with Developmental Disabilities’ Request for Services Registry, also known as *Chisholm* Class Members;
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE), a community-based alternative to placement in a nursing facility that includes a complete “managed care” type benefit combining medical, social and long-term care services;
- Individuals with a limited eligibility period including:
 - **Spend-down Medically Needy Program** - An individual or family who has income in excess of the prescribed income standard can reduce excess income by incurring medical and/or remedial care expenses to establish a temporary period of Medicaid coverage (up to three months); and
 - **Emergency Services Only** - Emergency services for aliens who do not meet Medicaid citizenship/ 5-year residency requirements;
- Individuals enrolled in the LaCHIP Affordable Plan Program (LaCHIP Phase V) that provides benchmark coverage with a premium to

uninsured low-income children under age 19 who do not otherwise qualify for Medicaid or other LaCHIP programs; and

- Individuals enrolled in and receiving Family Planning services only in the Take Charge Program which provides family planning services to **uninsured** women ages 19 – 44 who are not otherwise eligible for any another Medicaid program.

6.2 Enrolling Medicaid/CHIP Eligibles in the CCN

6.2.1 The Enrollment Broker will inform the Medicaid/CHIP eligible of all CCNs available in their geographic area. The Enrollment Broker shall comply with the information requirements of 42 CFR §438.10 to ensure that, before enrolling, the individual receives, from the Broker, the accurate oral and written information he or she needs to make an informed decision on whether to enroll. This information shall be provided in accordance with S.S. 1932 and 42 CFR §438.104; in an objective, non-biased fashion that neither favors nor discriminates against any CCN or health care provider. The importance of early selection of a CCN shall be stressed, especially if the Medicaid/CHIP eligible indicates priority health needs. To assist Medicaid/CHIP eligibles in identifying participating providers for each CCN, the Enrollment Broker will maintain and update weekly, an electronic provider directory that is accessible through the Internet and will make paper provider directories available by mail.

6.2.2 The Enrollment Broker shall assist the Medicaid/CHIP eligible with the selection of a CCN that meets the individual's needs by explaining in a non-biased manner the criteria that may be considered when selecting a CCN. Medicaid/CHIP enrollees who are eligible for the CCN Program will have fifteen (15) calendar days from the postmark date that an enrollment form is sent to them by the Enrollment Broker to select a CCN. All members of a family unit will be required to select the same CCN unless extenuating circumstances warrant a different CCN. Such instances must be approved by DHH.

6.2.3 The CCN shall have written policies and procedures for notifying new members within ten (10) business days after receiving notification from the Enrollment Broker of enrollment. This notification must be in writing and include a listing of primary care providers' name, location, and office telephone numbers that the enrollee may choose as their primary care provider.

- 6.2.4** The CCN shall not discriminate against CCN members on the basis of their health history, health status or need for health care services or adverse change in health status; or on the basis of age, religious belief, sex/gender, or sexual orientation. This applies to enrollment, re-enrollment or disenrollment from the CCN. The CCN shall provide services to all eligible CCN members who enroll in the CCN.
- 6.2.5** The CCN may not restrict choice of the provider from whom the person may receive family planning services and supplies.
- 6.2.6** The Enrollment Broker’s automatic assignment methodology shall take into consideration factors, such as, but not limited to:
- Medicaid/CHIP eligible’s geographic parish of residence;
 - CCN geographic services area (preference will be given to CCNs with a service area that includes all parishes within the region)
 - Provider capacity;
 - Previous linkage with a CommunityCARE PCP (at transition from CommunityCARE to CCN);
 - Quality Indicators (when available); and
 - Provider practice restrictions/limits.

6.3 Enrollment Period

The CCN members shall be enrolled for a period of twelve (12) months contingent upon their continued Medicaid/CHIP eligibility. The member may request disenrollment, without cause, at any time during the ninety (90) days following the date of the member’s initial enrollment or re-enrollment with the CCN. See § 6.7 for disenrollment procedures.

Annually, DHH will mail a re-enrollment offer to CCN members to determine if they wish to continue to be enrolled with the CCN. Unless the member becomes ineligible for the CCN Program or provides written, oral or electronic notification that they no longer wish to be enrolled in the CCN, the member will remain enrolled with the CCN.

A CCN member who becomes disenrolled due to loss of Medicaid/CHIP eligibility, but regains Medicaid/CHIP eligibility within sixty (60) calendar days will be automatically enrolled in the CCN with which the member was previously associated. Depending on the date eligibility is regained; there may be a gap on the member’s CCN coverage. If Medicaid/CHIP eligibility is regained after sixty (60) days, the reinstatement of Medicaid/CHIP eligibility will prompt DHH’s Enrollment Broker to mail an enrollment packet to the

Medicaid/CHIP eligible. The Medicaid/CHIP eligible may also initiate the re-enrollment process without an enrollment packet. See §6.7 for additional information on re-enrollment and the *CCN-S Policy and Procedure Guide – Re-enrollment Section*.

6.4 Selection or Assignment of a Primary Care Provider (PCP)

The CCN shall have written policies and procedures for assignment of its members to a primary care provider. The CCN is responsible for linking all Medicaid/CHIP enrollees to a primary care provider. The CCN shall be responsible for providing to the Enrollment Broker information on the capacity of each individual PCP on a quarterly basis.

If the member does not select a PCP and is auto assigned to a PCP by the CCN, the CCN shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP. After the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve (12) months beginning from the original date the member was assigned to the CCN. If a member requests to change his or her primary care provider with cause, at any time during the enrollment period, the CCN must agree to grant the request.

6.5 Enrollment of Newborns

Newborns of Medicaid eligible mothers who were enrolled at the time of the newborn's birth will be automatically enrolled with the mother's CCN, retroactive to the month of the birth.

6.6 CCN Follow Up of Voluntary Disenrollees

The CCN may conduct an initial follow up for all voluntary disenrollees. These members will be identified on the member listing file with a special indicator. DHH will provide the CCN with a member listing file (enrollments and disenrollments). The CCN may contact the member upon receipt of the member listing file. However, follow up must be within the guidelines outlined in *CCN-S Policy and Procedure Guide, Member Education and Enrollment Sections*.

6.7 Member Initiated Disenrollment and Change of CCN

A member shall remain in the CCN unless the member submits a written, electronic or oral request to disenroll, transfer to another CCN for cause or the member becomes ineligible for Medicaid and/or CCN enrollment. The member may disenroll from the CCN by:

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- Requesting disenrollment, without cause, at any time during the ninety (90) days following the date of the member's initial enrollment or re-enrollment with the CCN;
- Requesting disenrollment, with cause, after the first 90 days through a written, electronic or oral request to disenroll. or transfer to another CCN; or
- Becoming ineligible for Medicaid/CHIP and/or CCN enrollment.

Oral requests to disenroll shall be confirmed by the Enrollment Broker by return call with written documentation, or in writing to the requestor. If a member's request to disenroll is not acted on within sixty (60) days, the request for disenrollment shall be considered approved.

A member who is a voluntary enrollee (See §6.1 of this Provider Agreement) may request disenrollment from a CCN without cause at any time.

In accordance with 42 CFR §438.56(c) a member who is a mandatory enrollee may request disenrollment from the CCN as follows:

- For cause, at any time. The following are considered cause for disenrollment by the member:
 - The member moves out of the CCN's service area;
 - The CCN does not, because of moral or religious objections, cover the service the member seeks;
 - The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the CCN's network of providers; and the member's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; and
 - Other reasons, including but not limited to, poor quality of care, lack of access to services specified under the Provider Agreement, or lack of access to providers experienced in dealing with the member's health care needs.

- Without cause, at the following times:
 - During the ninety (90) days following the date of the member's initial enrollment with the CCN or the date the Enrollment Broker sends the member notice of the enrollment, whichever is later;
 - At least once a year during the annual open enrollment period thereafter;
 - Upon automatic reenrollment under 42 CFR §438.56(c)(iii), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or
 - If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).

All member initiated disenrollment requests must be made to DHH's Enrollment Broker and the CCN shall refer all such requests that they receive to the Enrollment Broker. The CCN shall not approve or disapprove any request for disenrollment.

A member's request to disenroll must be acted on no later than the first day of the second month following the month in which the member filed the request. If not, the request shall be considered approved. If denied, as per 42 CFR §438.56(f)(2), the member may access the State Fair Hearing process outlined in § 9.7.5 of this Provider Agreement.

6.7.1 Member Choice Period

A member may request disenrollment, without cause, at any time during the ninety (90) days following the date of the member's initial enrollment or re-enrollment with the CCN. The request must be made to DHH's Enrollment Broker and may be verbal, written or electronic.

6.7.2 Member Disenrollment for Cause

A member in a CCN who is a mandatory enrollee and subject to the CCN "lock-in" period may initiate disenrollment or transfer after the first ninety (90) days of enrollment for **cause only**.

The following are cause for disenrollment:

- The member moves out of the CCN's designated service area.

- The CCN does not, because of moral or religious objections, cover the service the member seeks.
- The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the CCN; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- The Provider Agreement between the CCN and DHH is terminated.
- The CCN has been sanctioned.
- The member loses Medicaid/CHIP eligibility.
- The member is placed in a nursing facility or intermediate care facility for people with developmental disabilities.
- The member changes to an excluded group.
- To implement the decision of a hearing officer in an appeal proceeding by the member against the CCN or as ordered by a court of law; and /or
- Other reasons, including but not limited to:
 - Poor quality of care;
 - Lack of access to services covered under the Provider Agreement;
 - Lack of access to providers experienced in dealing with the enrollee's health care needs.

6.8 CCN Initiated Member Disenrollment

The CCN may request disenrollment of a member with a written request to DHH providing the member's name, Medicaid ID number, and detailed reasons for requesting the reassignment of the member. The CCN shall not request disenrollment for reasons other than those permitted under this Provider

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Agreement and/or in accordance with Louisiana Medicaid State Plan, rules, regulations and policy and procedures.

With proper documentation, the following are acceptable reasons for which the CCN may submit involuntary disenrollment requests to DHH's Enrollment Broker:

- Fraudulent use of the CCN's ID card. In such cases the CCN shall report the event to the Medicaid Program Integrity Section.
- The member's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members and such behavior is not linked to the member's diagnosis.
 - The CCN shall promptly submit such disenrollment requests to DHH. In no event shall the CCN submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The CCN shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.
 - All requests will be reviewed on a case-by-case basis and subject to the sole discretion of DHH. All decisions are final and not subject to CCN dispute or appeal.

The CCN may not request disenrollment because of a member's:

- Health diagnosis;
- Adverse change in health status;
- Utilization of medical services;
- Diminished mental capacity;
- Pre-existing medical condition;
- Refusal of medical care or diagnostic testing;

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- Uncooperative or disruptive behavior resulting from his or her special needs, unless it seriously impairs the CCN's ability to furnish services to either this particular member or other members as defined in this subsection;
- Attempt to exercise rights under the CCN's grievance system; or
- Request of one (1) PCP to have a member assigned to a different provider out of the CCN.

The CCN shall not attempt to discourage enrollment of prospective members or encourage disenrollment from the CCN of current members. DHH considers this a material violation and the CCN will be subject to intermediate sanctions.

Disenrollment shall be assisted and completed by the Enrollment Broker and in a manner so designated by DHH.

When the CCN requests an involuntary disenrollment, it shall notify the member in writing that the CCN is requesting a disenrollment, the reason for the disenrollment request, and an explanation that the CCN is requesting that the member be disenrolled in the next month, or earlier if necessary. Until the CCN receives written approval for involuntary disenrollment from DHH, the CCN shall continue services to the member.

DHH will determine if the CCN has shown good cause to disenroll the member and DHH will give written notification to the CCN and the member of its decision. The member shall have the right to appeal any adverse decision.

If the CCN ceases participation in the Medicaid/CHIP enrollee's service area or ceases participation in the CCN Program, the CCN shall notify DHH in accordance with the termination procedures in **§13.3.4.8** of this Provider Agreement. DHH will notify CCN program members and offer them the choice of another CCN, if there is CCN with capacity in their service area. If there are no other CCN options, they will be placed in fee-for-service. The CCN shall assist DHH in transitioning CCN members to another CCN or to the Medicaid fee-for-service delivery system to ensure access to needed health care services.

6.9 DHH Initiated Member Disenrollment

The DHH will notify the CCN of the member's disenrollment due to the following reasons:

- Loss of Medicaid/CHIP eligibility or loss of CCN mandatory or voluntary status;

- Death of a Member;
- Member becomes an inmate (see *Appendix A – Definition of Terms*) of a Public Institution;
- Member moves out of state;
- Member becomes Medicare Eligible;
- Member elects hospice;
- Member becomes institutionalized in a Long Term Care Facility/Nursing Home; and
- Member elects Home and Community Based Waiver Programs.

6.10 Notification of Membership to CCN

DHH will notify each CCN at specified times each month of the Medicaid/CHIP eligibles that are enrolled, re-enrolled, or disenrolled from their CCN for the following month. The CCN will receive this notification through electronic media. See *CCN-S Policy and Procedure Guide* for record layout.

DHH will use its best efforts to ensure that the CCN receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or unresolvable differences between DHH and the CCN, regarding enrollment, disenrollment and/or termination, DHH’s decision is final.

6.11 Call Center for CCN Enrollment Questions

DHH, through its Enrollment Broker contractor, will maintain a toll-free telephone number for Medicaid/CHIP eligibles to call and ask questions or obtain information about the enrollment process and other information, as specified in the *CCN-S Policy and Procedure Guide*, including but not limited to, Coordinated Care Networks that are available to them.

6.12 Tracking Linkage Availability

The CCN shall identify the maximum number of CCN members it is able to enroll and maintain under this Provider Agreement prior to initial enrollment of Medicaid/CHIP eligibles. The CCN shall accept Medicaid/CHIP eligibles as CCN members in the order in which they are submitted by the Enrollment Broker without restriction, in accordance with 42 CFR §438.6 (d)(1) and as specified by DHH, up to the limits specified in *CCN-S Policy and Procedure Guide*. The CCN agrees to provider enhanced primary care case management services to CCN members up to the maximum enrollment limits indicated for the CCN in the *CCN-S Policy and Procedure Guide*. DHH reserves the right to

approve or deny the maximum number of CCN members to be enrolled in the CCN based on DHH's determination of the adequacy of CCN capacity.

On a quarterly basis consistent with the *CCN-S Policy and Procedures Guide*, CCN is to update their maximum enrollment by designated service area. The CCN shall track slot availability and notify DHH's Enrollment Broker when filled slots are near capacity. Upon notification, DHH or the Enrollment Broker will not assign any other eligibles to that CCN without first consulting the CCN. The CCN is responsible for maintaining a record of PCP linkages with Medicaid/CHIP members and provider information quarterly to DHH.

DHH will notify the CCN when the CCN's enrollment levels are maximized and will not enroll Medicaid/CHIP eligibles when there are no more slots available.

6.13 Enrollment Data Reconciliation

If the CCN desires a reconciliation of the enrollment, re-enrollment, and disenrollment data received from DHH, the CCN shall be responsible for that reconciliation. In the event of discrepancies, the CCN shall notify the Enrollment Broker immediately of the discrepancy, however, DHH as the regulatory agency, will make the final determination in any disparities that arise from the reconciliation process.

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7 **MARKETING**

Marketing is defined as any communication from a CCN to a Medicaid/CHIP eligible who is not enrolled in that CCN, that can reasonably be interpreted to influence the individual to enroll in that particular CCN's Medicaid product, or either to not enroll in, or disenroll from, another CCN's Medicaid product. All such marketing, informational and instructional materials shall be written in manner and format that may be easily understood, as specified in 42 CFR § 438.10(b)(1), and at a reading comprehension level no higher than a 6.9 grade level, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy. The text must be printed in at least ten-point font, preferably twelve-point font. Activities involving distribution and completion of the CCN enrollment form during the course of enrollment activities is an enrollment function and is considered separate and distinct from marketing and is the sole responsibility of DHH's Enrollment Broker.

Under the Louisiana Coordinated Care Program, all direct marketing to eligibles or potential eligibles will be performed by DHH or its designee in accordance with 42 CFR §438.104 . The CCN shall not market directly or indirectly to Medicaid/CHIP potential enrollees (including direct mail advertising, "spam", door-to-door, telephonic, or other "cold call" marketing). The CCN shall not sponsor or attend any marketing activities without notifying DHH. No CCN outreach or marketing shall precede the successful completion of the CCN enrollment process and readiness review or, for initial phase-in of CCN's, the launch of the Enrollment Broker information and education campaign. All marketing and educational materials must be approved by DHH prior to use. All marketing/advertising and member education activities and materials must comply with the requirements set forth in *the CCN-S Policy and Procedure Guide*. The CCN shall not release any materials related to this Provider Agreement, including but not limited to, enrollment materials, press releases, and articles, without the prior written approval of DHH

DHH may impose sanctions against the CCN if DHH determines that the CCN distributed directly/indirectly or through any agent, network provider, or independent contractor, marketing materials and/or CCN enrollment forms in violation of this Provider Agreement.

7.1 Marketing Plan and Materials

The CCN shall develop and implement a marketing plan, incorporating DHH's marketing requirements, for participation in the Coordinated Care Program. The CCN shall provide a marketing plan detailing the marketing activities it will undertake during the Provider Agreement period. The CCN's marketing plan shall take into consideration the projected enrollment levels. The CCN shall notify DHH of their participation in each community event designed to increase community awareness of their participation in the Coordinated Care Program.

Marketing plan requirements are detailed in the *CCN-S Policy and Procedure Guide*.

Enrollment activities by the CCN are **specifically prohibited**. Only written materials describing the CCN, as approved by DHH, can be distributed at such events. All marketing activities shall comply with *CCN-S Policy and Procedure Guide* and this Provider Agreement.

Marketing materials cannot contain any assertion or statement (whether written or oral) that an individual must enroll in the CCN in order to obtain Medicaid or CHIP benefits or in order not to lose Medicaid or CHIP benefits. Marketing materials cannot include any inference that the CCN is endorsed by CMS, the Federal or State government or similar entity.

The CCN must distribute marketing materials to its entire service area as indicated in the Provider Agreement

The CCN shall not seek to influence enrollment in the CCN in conjunction with the sale or offering of any private insurance.

Materials used for the purpose of marketing to CCN members must be prior approved by DHH and meet the standards for marketing materials outlined in *CCN-S Policy and Procedure Guide*.

The CCN shall ensure that where five percent (5%) of the Medicaid population of a parish is non-English speaking and speaks a specific foreign language, materials shall be made available, free of charge to the member, in that specific language to assure a reasonable chance for all potential members to make an informed choice of CCN as specified in 42 CFR §438.10(c) (4) and (5).

All written materials must use easily understood language and format; written at a reading comprehension level no higher than a 6.9 grade level. All written material must be available in alternative formats in appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency as required in 42 CFR §438.10(d)(1)(i) and (ii) and (2).

The CCN must provide DHH with a copy of all publications and displays, including information on when and where they will appear.

7.2 Approval of Marketing Plan and Materials

The CCN shall submit to DHH or its designee all marketing plans and written materials directed at Medicaid eligibles, current CCN members or potential

eligibles for approval in accordance with the *CCN-S Policy and Procedure Guide*. These materials include, but are not limited to: materials produced for marketing, member education, and evidence of coverage; member handbook and grievance procedures; all types of media including brochures, leaflets, newspapers, magazines, radio, television, internet-based materials, billboard and yellow page advertisements directed at Medicaid eligibles, current CCN members or potential eligibles.

7.2.1 The CNN shall assure DHH that marketing, including plans and materials, are accurate and do not mislead, confuse, or defraud the potential enrollee/enrollee or DHH as specified in Social Security Act § 1932 (d) and 42 CFR § 438.104. Marketing materials must follow the guidance of the *CCN-S Policy and Procedure Guide*, which details prohibited actions as well as written guidance.

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8 POST ENROLLMENT PROCESS

DHH's Enrollment Broker shall send the CCN a weekly eligibility file. The file shall contain the names, addresses and phone numbers of all newly eligible enrollees assigned to the CCN and an indicator for individuals who are automatic assignments. The CCN shall use the file to identify new members to whom the CCN shall conduct a welcome call and send a welcome packet in accordance with the *CCN-S Policy and Procedure Guide*.

The CCN post enrollment process shall provide:

8.1 Member Identification Card

The CCN shall issue an identification (ID) card within fourteen (14) calendar days of the receipt of information from DHH or the Enrollment Broker.

A list of required ID card information is outlined in *CCN-S Policy and Procedure Guide*.

The CCN shall also insure that its contractors/network providers can identify members, in a manner which will not result in discrimination against the members, in order to provide or coordinate the provision of all authorized services.

8.2 Member Services Availability

The CCN shall maintain an organized, integrated member/patient services function, to be operated during regular business hours, within the CCN to assist members in selection of a primary care provider, provide explanation of the CCN's policies and procedures, (re: access and availability of health services) provide additional information about the primary care providers, facilitate referrals to specialists, and assist in the resolution of service and/or medical delivery problems and member grievances.

The CCN shall agree to maintain a toll-free telephone number for CCN members' inquiries. The toll-free telephone number shall be required to provide prior authorization/access and information on services during evenings and weekends.

Member Services and the Call Center must be physically located within the United States.

8.3 Member Education

The CCN shall submit to DHH an electronic copy of the procedures to be used to contact CCN members for initial member education for approval prior to Provider Agreement execution. These procedures shall adhere to the enrollment process and procedures outlined in §6 and the post enrollment procedures required in §8 of this Provider Agreement.

The CCN shall have written policies and procedures for educating CCN members about their benefits. The CCN shall educate members regarding the appropriate utilization of services; access to emergency care; and the process for prior authorization of services. Such education shall be provided no later than ten (10) business days from receipt of enrollment data from DHH or its designee, and as needed thereafter. The CCN shall identify and educate members who access the system inappropriately and provide continuing education as needed.

The CCN must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood. Written material must use easily understood language and format and written at a 6.9 grade reading level as specified in this Provider Agreement and the *CCN-S Policy and Procedure Guide*. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

The CCN must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana identifies as prevalent (Spanish and Vietnamese). The enrollee is not to be charged for interpretation services. The CCN must notify its enrollees that oral interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services.

Include the following notifications as well:

- a. Notify all enrollees of their right to request and obtain the welcome packet at least once a year.
- b. Furnish to each of its enrollees the information specified in this Provider Agreement and the *CCN-S Policy and Procedure Guide* within a

reasonable time after the CCN receives, from the State or its contracted representative, notice of the recipient's enrollment.

Give each enrollee written notice of any material change at least thirty (30) calendar days before the intended effective date of the change.

The CCN shall ensure that where at least five percent (5%) or more of the resident population of a parish and/or designated service area is non-English speaking and speaks a specific foreign language, then materials must be made available, at no charge to the member, in that specific language to assure a reasonable chance for all members to understand how to access the CCN and use services appropriately.

The CCN shall coordinate with DHH or its designee member education activities as outlined in *CCN-S Policy and Procedure Guide* to meet the health care educational needs of the CCN members.

The CCN shall not discriminate against CCN members on the basis of their health history, health status or need for health care services. This also applies but is not limited to, enrollment, re-enrollment or disenrollment from the CCN.

8.3.1 Member Welcome Packets

The CCN shall send welcome packets to new members within ten (10) business days from the effective date of enrollment into the CCN. All contents of the welcome packet shall be reviewed and approved in writing by DHH prior to distribution. The welcome packet shall include, but is not limited to:

- A welcome letter highlighting major program features and contact information for the CCN;
- A Member Handbook;
- A Member Identification (ID) card; and
- Provider Directory (also may be available on-line).

8.3.2 Member Handbooks

Member handbooks must include, at a minimum, the following information:

- a. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients;
- b. Any restrictions on the enrollee's freedom of choice among CCN providers;

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- c. Enrollee rights and protections, as specified in § 438.100;
- d. Information on grievance and fair hearing procedures;
- e. The amount, duration, and scope of benefits available through the CCN in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- f. Procedures for obtaining benefits, including authorization requirements;
- g. The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers;
- h. The extent to which, and how, after-hours and emergency coverage are provided, including:
 - i. What constitutes emergency medical condition, emergency services, and poststabilization services, with reference to the definitions in § 438.114(a);
 - ii. The fact that prior authorization is not required for emergency services;
 - iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;
 - iv. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the Provider Agreement;
 - v. The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- i. The poststabilization care services rules set forth at § 422.113(c);
- j. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- k. Cost sharing, if any;
- l. How and where to access benefits that are available under the State plan but are not covered under the Provider Agreement, including any cost sharing, and how transportation is provided;
- m. For a counseling or referral service that the CCN does not cover because of moral or religious objections, the CCN need not furnish information on how and where to obtain.

8.4 Member's Rights and Responsibilities

The CCN shall furnish CCN members with both verbal and written information about the nature and extent of their rights and responsibilities as a member of the CCN.

8.4.1 Member Rights

The rights afforded to current members are detailed in *CCN-S Policy and Procedure Guide, Member's Bill of Rights*. The written information shall be written at a reading comprehension level no higher than grade 6.9, or as determined appropriate by DHH. The minimum written information shall include but not be limited to:

- a. The right to receive information as described in 42 CFR §438.10 and throughout the Provider Agreement;
- b. The right to be treated with respect and with due consideration for his or her dignity and privacy;
- c. The right to receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand;
- d. The right to participate in treatment decisions, including the right to refuse treatment; and the right to the following:
 - i. Complete information about their specific condition and treatment options, regardless of cost or benefit coverage, and to seek second opinions;
 - ii. Information about available experimental treatments and clinical trials and how such research can be accessed; and
 - iii. Assistance with care coordination from the PCP's office;
- e. The right to be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience;
- f. The right to express a concern or appeal about their CCN or the care it provides and receive a response in a reasonable period of time;

- g. The right to receive a copy of their medical records, including, if the HIPAA privacy rule applies, the right to request that the records be amended or corrected as allowed in 45 CFR § 164; and
- h. Freedom to exercise the rights described herein without any adverse effect on the member's treatment by DHH, the CCN or the CCN's contractors or providers.

8.4.2 Member Responsibilities

The CCN members' responsibilities shall include but are not limited to:

- a. Informing the CCN of the loss or theft of their ID card;
- b. Presenting their ID card when using health care services;
- c. Being familiar with the CCN procedures to the best of the member's abilities;
- d. Calling or contacting the CCN to obtain information and have questions clarified;
- e. Providing participating network providers with accurate and complete medical information;
- f. Following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; and
- g. Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services.

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9 GRIEVANCE AND STATE FAIR HEARING PROCEDURES

The CCN shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances in accordance with all applicable state and federal laws. All appeals received by the CCN must be logged and directly forwarded to the State Fair Hearing process. The CCN must assist DHH in handling appeals of its members through the State Fair Hearing process. The CCN shall work with DHH toward simultaneous resolution of any appeals brought to their attention. The CCN shall not create barriers to timely due process. The CCN shall be subject to sanctions if it is determined by the Department the CCN has created barriers to timely due process, and/or, if ten percent (10%) or higher of grievance decisions by the CCN have been overturned as a result of a State Fair Hearing decision within a twelve month period. Examples of creating barriers shall include but not be limited to:

- Binding arbitration clauses in CCN choice forms
- Failing to inform members of their due process rights
- Failing to log and process grievances
- Labeling complaints as inquiries and funneling them into an informal review
- Failure to issue a proper notice including vague or illegible notices
- Failure to inform of continuation of benefits
- Failure to inform of right to State Fair Hearing

The CCN's grievance procedures and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in this Provider Agreement and the *CCN-S Policy and Procedure Guide*. The CCN shall refer all CCN members who are dissatisfied with the CCN or its contractor in any respect to the CCN's designee authorized to review and respond to grievances and require corrective action.

9.1 Definitions

9.1.1 Action

A termination, suspension, or reduction (which includes denial of a service based on Federal Office of General Counsel interpretation of CFR 431) of Medicaid eligibility or covered services.

9.1.2 Appeal

A request for review of an action, as "action" is defined in this section.

9.1.3 Grievance

An expression of dissatisfaction about any matter other than an action, as “action” is defined in this section. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The term is also used to refer to the overall system that includes CCN-S level grievances and access to State Fair Hearing.

9.2 General Requirements

9.2.1 Grievance System

The CCN must have a system in place for members that include a grievance process, and access to the State Fair Hearing system.

9.2.2 Filing Requirements

9.2.2.1 Authority to File

9.2.2.1.1 A member or representative of their choice may file a grievance and may request a State Fair Hearing in response to an action.

9.2.2.1.2 A network provider may file a grievance or request a State Fair Hearing on behalf of a member in response to an action.

9.2.2.2 Timing

The member must be allowed thirty (30) calendar days from the date on the CCN's notice of action to request a State Fair Hearing. Within the timeframe the member, or a representative or provider acting on their behalf, may request a State Fair Hearing.

9.2.3 Procedures

9.2.3.1 The member may file a grievance either orally or in writing with the CCN.

9.2.3.2 The member, or a representative or provider acting on behalf of the member, may file for a State Fair hearing with the designated state entity either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed State Fair Hearing request.

9.3 Notice of Grievance and State Fair Hearing Procedures

The CCN shall ensure that all CCN members are informed of State Fair Hearing process and of the CCN's grievance procedures. The CCN shall provide to each member a member handbook that shall include descriptions of the CCN's grievance procedures. Forms on which members may file grievances, concerns or recommendations to the CCN shall be available through the CCN, and must be provided upon request of the member. The CCN shall make all forms easily available on the CCN's website.

9.4 Grievance Records and Reports

A copy of an oral grievances log shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.

The CCN shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in the *CCN-S Policy and Procedure Guide*, to include: member's name and Medicaid number, summary of grievances; date of filing; current status; resolutions and resulting corrective action. Reports with personal identifying member information redacted and will be made available for public inspection. All State Fair Hearing requests shall be sent directly to the state designated entity; however, if the CNN receives a request for a State Fair Hearing, the CCN will be responsible for promptly forwarding State Fair Hearing requests to the State Fair Hearing entity. DHH has the right to make final decisions regarding the resolution of any grievance. *See CCN-S Policy and Procedure Guide.*

9.5 Handling of Grievances

The grievance procedures shall be governed by the following requirements:

9.5.1 General Requirements

In handling grievances, the CCN must meet the following requirements:

9.5.1.1 Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

9.5.1.2 Acknowledge receipt of each grievance.

9.5.2 Resolution and Notification

Basic Rule: The CCN must dispose of a grievance and provide notice, as expeditiously as the member's health condition requires, within the timeframes established in § 9.5.3.1 below.

9.5.2.1 Specific Timeframes

9.5.2.1.1 Standard Disposition of Grievances

For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the CCN receives the grievance.

9.5.2.1.2 Extension of Timeframes

The CCN may extend the timeframes from § 9.7.1 of this section by up to fourteen (14) calendar days if:

- a. The member requests the extension; or
- b. The CCN shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.

9.5.2.1.3 Requirements Following Extension

If the CCN extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

9.5.3 Requirements for State Fair Hearings

9.5.3.1 Availability

The member may request a State Fair Hearing within thirty (30) days from the date of the notice of action following the resolution of the grievance.

9.5.3.2 Parties

The parties to the State Fair Hearing include the CCN as well as the member and his or her representative or the representative of a deceased member's estate.

9.5.3.3 Concurrent Appeal Review

The CCN shall conduct an internal concurrent review for which a State Fair Hearing was requested. The purpose of the Concurrent Appeal Review is to expedite the resolution of the appeal to the satisfaction of the member, if possible, prior to the State Fair Hearing. The CCN shall notify the State Fair Hearing designated entity of Concurrent Appeal reviews resulting in a resolution in favor of the member. The Concurrent Appeal Review shall not delay the CCN's submission of an appeal to the State Fair Hearing process and shall not delay the review of the appeal in the State Fair Hearing.

9.5.4 Special Requirements for State Fair Hearing

All State Fair Hearing by members or on their behalf shall be filed with the state designated entity; however, if the CNN receives a State Fair Hearing request, the request shall be forwarded directly to the designated entity that will conduct the State Fair Hearing.

9.5.4.1 The CCN's staff shall be educated concerning the importance of the State Fair Hearing procedures and the rights of the member and providers.

9.5.4.2 The appropriate individual or body within the CCN that made the decision that is being brought to the State Fair Hearing shall be identified. This individual shall prepare the Summary of Evidence and be available for the State Fair Hearing either in person or by telephone.

9.6 Notice of Action

Notice of Action will only be sent by the CCN in certain circumstances as specified in the *CCN-S Policy and Procedure Guide*.

9.6.1 Language and Format Requirements

The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) and the *CCN-S Policy and Procedure Guide* to ensure ease of understanding.

9.6.2 Content of Notice

The notice must explain the following:

9.6.2.1 The action the CCN or its contractor has taken or intends to take;

9.6.2.2 The reasons for the action;

9.6.2.3 The member's right to request a State Fair Hearing and a number to call for free Legal Advice;

9.6.2.4 The procedures for exercising the rights specified in this section;

9.6.2.5 The circumstances under which expedited resolution is available and how to request it; and

9.6.2.6 The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services.

9.6.2.7 A statement in Spanish and Vietnamese that translation assistance is available at no cost and the toll free number to call to receive translation of the notice.

9.6.3 Timing of Notice

The CCN must mail the notice within the following timeframes:

9.6.3.1 For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action, except as permitted under 42 C.F.R. §§ 431.213 and 431.214.

9.6.3.2 For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:

9.6.3.2.1 The member, or the provider, requests extension; or

9.6.3.2.2 The CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

9.6.3.3 If the CCN extends the timeframe in accordance with §§ 9.6.3.2.1 or 9.6.3.2.2, it must:

9.6.3.3.1 Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

9.6.3.3.2 Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

9.6.3.4 On the date the timeframe for service authorization as specified in § 9.6.3.2 expires.

9.6.3.5 For expedited service authorization decisions where a provider indicates, or the CCN determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service.

The CCN may extend the three (3) working days time period by up to fourteen (14) calendar days if the member requests an extension, or if the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.

9.6.3.6 DHH may conduct random reviews to ensure that members are receiving such notices in a timely manner.

9.7 Continuation of Benefits While the State Fair Hearing Is Pending

9.7.1 Per 42 CFR §431.230, if the enrollee requests a hearing before the date of action or within ten (10) days from the postmark of the notice, the agency may not terminate or reduce services until a decision is rendered after the hearing unless:

9.7.1.1 It is determined at the hearing that the sole issue is one of Federal/state law or policy; and

9.7.1.2 The agency promptly informs the recipient in writing that services are to be terminated/reduced pending the hearing decision.

9.7.2 Member Responsibility for Services Furnished While the State Fair Hearing is Pending

If the final resolution of the appeal is adverse to the member, that is, upholds the CCN's action, the State may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 C.F.R. §431.230(b).

9.8 Information about the Grievance System to Providers and Contractors

The CCN must provide the information about the grievance system to all providers and contractors at the time they enter into a contract as specified in the *CC -S Policies and Procedures Guide*.

9.9 Recordkeeping and Reporting Requirements

Reports of grievances and resolutions shall be submitted to DHH as specified in §§ 9.4 and 10.2 of this Provider Agreement. The CCN shall not modify the grievance procedure without the prior written approval of DHH.

9.10 Effectuation of Reversed Decision Resolutions

9.10.1 Services not furnished while the appeal is pending

If the CCN or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the State Fair Hearing was pending, the CCN must authorize the disputed services promptly, and as expeditiously as the member's health condition requires.

9.11 Training of CCN Staff

The CCN's staff, including Member Services and Call Center staff, shall be educated concerning the importance of the grievance procedures and rights of the member and providers.

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10 REPORTING REQUIREMENTS

The CCN is responsible for complying with all the reporting requirements established by DHH.

The CCN must demonstrate the capability to connect to DHH's FI using TCP/IP protocol on a specific port at no cost to DHH or its FI. Connectivity must be verified by DHH's FI to DHH in writing. The CCN shall provide DHH a sample of all hard copy reports as specified in the CCN Enrollment Process (See *CCN-S Policy and Procedure Guide*). The requirements for electronic files submissions are specified in the *CCN-S Policy and Procedure Guide and CCN-S Systems Companion Guide*.

The CCN shall provide to DHH and any of its designee's copies of agreed upon reports generated by the CCN concerning CCN members and any additional reports as requested in regard to performance under this Provider Agreement.

DHH will provide the CCN with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. All reports shall be submitted in accordance with the schedule outlined in the §13.3.1 of this Provider Agreement. In the event that there are no instances to report, the CCN shall submit null reports. The required formats and reports, and reporting periods are outlined in *CCN-S Policy and Procedure Guide and/or CCN-S Systems Companion Guide*.

The CCN-S shall certify certain submitted data, documents and reports. The data that must be certified include, but are not limited to, enrollment information, financial reports, and other information as specified by DHH. The certification must attest, based on best knowledge, information, and belief to the accuracy, completeness and truthfulness of the data; and to the accuracy, completeness and truthfulness of the documents and data.

The data shall be certified by one of the following:

- (1) CCN's Chief Executive Officer (CEO);
- (2) CCN's Chief Financial Officer (CFO); or
- (3) An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

Certification shall be submitted concurrently with the certified data.

10.1 CCN's Network of Providers and Contractors

The CCN shall furnish to DHH and/or its designee a monthly report of all network providers and contractors enrolled in the CCN's network.

The CCN shall also furnish to DHH or its designee adequate copies of the PCP listing as requested by DHH. DHH will provide the CCN with Medicaid provider identification numbers.

It shall be the CCN's responsibility to assure confidentiality of the Medicaid Providers' identification number and indemnity of DHH in accordance with § 14.25 of this Provider Agreement.

DHH is to be provided advance copies of all updates that include material changes not less than ten (10) business days in advance of distribution. Any provider no longer taking new patients must be clearly identified. Any age restrictions for a provider must be clearly identified.

10.2 Grievances Log Summary Reporting

The CCN shall log grievance information regarding all active and resolved grievances on a monthly basis and submit the log to DHH monthly. Any State Fair Hearing requests forwarded to the State should be noted on the log. The required format is identified in *the CCN-S Policy and Procedure Guide*.

10.3 Disenrollment Reporting

The CCN shall submit to DHH disenrollment requests for approval in accordance with §§6.6 and 6.7 in this Provider Agreement. The CCN shall immediately notify DHH when it obtains knowledge of any CCN member whose enrollment should be terminated. See *CCN-S Policy and Procedure Guide* for procedures for disenrollment reporting.

10.4 EPSDT Reporting

The CCN shall accurately report to DHH all EPSDT and well-child services, referrals for corrective treatment as a result of well-child screenings, blood lead screenings, and access to preventive services as required for the mandated CMS 416 report as specified in the *CCN-S Policy and Procedure Guide*.

10.5 Quality Assessment and Performance Improvement

The CCN will submit reports of Quality Assessment and Performance Improvement (QAPI) activities in accordance with the reporting section and periodicity contained in § 4.7 of this Provider Agreement and *the CCN-S Policy and Procedure Guide*.

The CCN shall report to DHH results of all performance measures quarterly, annually, and upon Department request.

The CCN shall submit a description of the PIP with results in a format approved by DHH in accordance with *CCN-S Policy and Procedure Guide*.

The CCN shall report to DHH an evaluation of the impact and effectiveness of its QAPI program annually. This shall include, but is not limited to, § 4.1 - § 4.9.

10.6 Member Satisfaction Survey

The CCN shall conduct an annual Member Satisfaction Survey, utilizing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and methodology. The CCN will submit the survey results and a description of the survey process, including the survey tool and methodology used, to DHH. DHH will coordinate with the CCN to determine the schedule for conducting the survey and submitting the results to DHH. The CCN shall utilize a NCQA certified CAHPS vendor to conduct Member surveys.

10.7 Provider Satisfaction Survey

The CCN will conduct an annual Provider Satisfaction Survey utilizing a survey tool and methodology approved by DHH. DHH will coordinate with the CCN to determine the schedule for conducting the survey and submitting the results to DHH in accordance with the *CCN-S Policy and Procedure Guide*.

10.8 Additional Reports

The CCN shall prepare and submit any other reports as required and requested by DHH, any of DHH designees, and/or CMS, that is related to the CCN's duties and obligations under this Provider Agreement. Information considered to be of a proprietary nature shall be clearly identified as such by the CCN at the time of submission. DHH will make every effort to provide a sixty (60) day notice of the submission to give the CCN adequate time to prepare the reports.

10.9 Information Related to Business Transactions

The CCN agrees to furnish to DHH or to the U.S. Department of Health & Human Services (HHS) information related to significant business transactions as set forth in 42 CFR § 455.105 . Failure to comply with this requirement may result in termination of this Provider Agreement.

The CCN also agrees to submit, within thirty-five (35) days of a request made by DHH, full and complete information about:

- a. The ownership of any contractor with whom the CCN has had business transactions totaling more than twenty-five thousand dollars (\$25,000) during the 12-month period ending on the date of this request; and

- b. Any significant business transactions between the CCN and any wholly owned supplier, or between the CCN and any contractor, during the five-year period ending on the date of this request.

For the purpose of this Provider Agreement, “significant business transactions” means any business transaction or series of transactions during any state fiscal year that exceed the twenty-five thousand dollar (\$25,000) or 5% of the CCN’s total operating expenses whichever is greater.

10.10 Information on Persons Convicted of Crimes

The CCN agrees to furnish DHH and HHS information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) and CHIP (Title XXI) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Provider Agreement.

10.11 Errors

The CCN agrees to prepare complete and accurate reports for submission to DHH as defined in § 13.3.1 and in the format described in the *CCN-S Policy and Procedure Guide*. If after preparation and submission, a CCN error is discovered either by the CCN or DHH, the CCN shall to correct the error(s) and submit accurate reports as follows:

- a. For all reports – Fifteen (15) calendar days from the date of discovery by the CCN or date of written notification by DHH (whichever is earlier). DHH may, at its discretion, extend the due date if an acceptable corrective action plan has been submitted and the CCN can demonstrate to DHH’s satisfaction the problem cannot be corrected within fifteen (15) calendar days.

Failure of the CCN to respond within the above specified timeframes may result in a loss of any money due the CCN and the assessment of monetary penalties as provided in § 13.3.1 of this Provider Agreement.

10.12 Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of the CCN (42 CFR §455.100-455.104). Form CMS 1513, Ownership and Control Interest Statement, is to be submitted to DHH with this Provider Agreement; then resubmitted prior to implementation for each Provider Agreement period or when any change in the CCN’s management, ownership or control occurs. The

Provider Agreement for Coordinated Care Networks – Shared Savings

CCN agrees to report any changes in ownership and disclosure information to DHH within thirty (30) calendar days prior to the effective date of the change.

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11 MONITORING

11.1 Inspection, Evaluation and Audit of Records

At any time, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Provider Agreement period and for a period of six (6) years from the expiration date of this Provider Agreement (including any extensions to the Provider Agreement), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of this Provider Agreement and *CCN-S Policy and Procedure Guide* and any other applicable rules.

The CCN and contracted providers shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with CCN clients and employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by this Provider Agreement. See *CCN-S Policy and Procedure Guide*.

The State and HHS may inspect and audit any financial records of the entity or its subcontractors. There shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

The CCN and all of its contractors will make office work space available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provisions of services under this Provider Agreement. If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is the later. This provision is applicable to any contractor and must be included in all contracts. DHH and/or any designee will also have the right to:

- 11.1.1 Inspect and evaluate the qualifications and certification or licensure of CCN's contractors;

- 11.1.2 Evaluate, through inspection of CCN and its contractor's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to members;
- 11.1.3 Evaluate the CCN's performance for the purpose of determining compliance with the requirements of the Provider Agreement;
- 11.1.4 Audit and inspect any of CCN's or its contractor's records that pertain to health care or other services performed under this Provider Agreement; determine amounts payable under this Provider Agreement; or the capacity of the CCN to bear the risk of financial losses;
- 11.1.5 Audit and verify the sources of data and any other information furnished by the CCN in response to reporting requirements of this Provider Agreement, including data and information furnished by contractors;
- 11.1.6 The CCN agrees to provide, upon request, all necessary assistance in the conduct of the evaluations, inspections, and audits.
- 11.1.7 DHH shall monitor enrollment and termination practices and ensure proper implementation of the CCN's grievance procedures, in compliance with 42 CFR §438.226-438.228. DHH and its designee shall have access to all information related to complaints and grievances and appeals filed by CCN members.

The CCN agrees that all statements, reports and claims, financial and otherwise, shall be certified as true, accurate, and complete, and the CCN shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, this Provider Agreement, and DHH policy.

11.2 Medical Records Requirements

The CCN will require network providers/contractors to maintain up-to-date medical records at the site where medical services are provided for each CCN member enrolled under this Provider Agreement. Each member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. The CCN shall ensure within its own provider network that DHH representatives or its designee shall have immediate and complete access to all records pertaining to the health care services provided to CCN members. Medical record requirements are further defined in the *CCN-S Policy and Procedure Guide*. The CCN's Notice of Privacy Practices shall put members on

notice that their information will be subject to treatment, payment and operations disclosures within the CCN.

11.3 Record Retention

All records originated or prepared in connection with CCN's performance of its obligations under this Provider Agreement, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the CCN and its contractors in accordance with the terms and conditions of this Provider Agreement.

The CCN further agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under this Provider Agreement, and as further required by DHH, for a period of six (6) years from the expiration date of the Provider Agreement, including any Provider Agreement extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If the CCN stores records on microfilm or microfiche, CCN hereby agrees to produce at CCN's expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.

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12 DHH RESPONSIBILITIES

12.1 DHH Provider Agreement Management

DHH will be responsible for the administrative oversight of the Coordinated Care Networks. As appropriate, DHH will provide clarification of Coordinated Care Network requirements and Medicaid policy, regulations and procedures. DHH will be responsible for oversight of this Provider Agreement. All Medicaid policy decision making or Provider Agreement interpretation will be made solely by the DHH. The oversight of this Provider Agreement will be conducted in the best interests of DHH and the CCN members.

Whenever DHH is required by the terms of this Provider Agreement to provide written notice to the CCN, such notice will be signed by the Medicaid Deputy Director which oversees the Medicaid Coordinated Care Section or the Medicaid Director.

12.2 Payment of Enhanced Care Management PMPM Rate

The CCN shall be paid in accordance with the PMPM rates specified in *Appendix F – Schedule of Enhanced Primary Care Case Management Fee Rates*.

12.3 Required Submissions

Prior to execution of this Provider Agreement, the CCN shall submit the DHH Required Submissions documents, as described in the *CCN-S Policy and Procedure Guide*. DHH shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the CCN's responsibilities under this Provider Agreement. Upon approval of the Required Submissions, CCN shall submit a complete copy of all Required Submission documents in a format specified in the *CCN-S Policy and Procedure Guide*. Thereafter, on January 15th of each year, the CCN shall submit, in the aforementioned format, only approved additions, changes and modifications which have been submitted and approved during this year.

12.4 Immunization Data

DHH will enroll all providers in the Louisiana Immunization Network for Kids Statewide (LINKS) web-based immunization reporting system for the reporting of all adult and child vaccinations.

12.5 Notification of Coordinated Care Network Program Policies and Procedures

CCN agrees to be bound by this Provider Agreement, the *CCN-S Policy and Procedure Guide, Companion Guides* and any applicable rules or regulations

published by DHH. DHH will provide the CCN with updates to appendices, information and interpretation of all pertinent federal and state Medicaid regulations, CCN policies, procedures and guidelines affecting the provision of services under this Provider Agreement. The CCN will submit written requests to DHH for additional clarification, interpretation or other information in a grid format specified by DHH. Provision of such information does not relieve the CCN of its obligation to keep informed of applicable federal and state laws related to its obligations under this Provider Agreement.

12.6 Provider Participation

The Program Integrity Section will update the Health Care Integrity and Protection Databank (HIPDB) to reflect all permissive and mandatory provider exclusions. The CCN shall be required to query the HIPDB for excluded providers at: <http://www.npdb-hipdb.hrsa.gov/index.html>.

CCNs shall also check the Excluded Parties List System website at www.EPLS.gov and the Office of Inspector General Exclusion Database website at <http://exclusions.oig.hhs.gov/search.aspx> for excluded providers.

12.7 Quality Assessment and Monitoring Activities

DHH will monitor the CCN's performance to assure the CCN is in compliance with the Provider Agreement provisions and the *CCN-S Policy and Procedure Guide*. However this does not relieve the CCN of its responsibility to continuously monitor its provider's performance in compliance with the Provider Agreement provisions and the *CCN-S Policy and Procedure Guide*.

DHH or its designee shall coordinate with the CCN to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.

DHH or its designee will, at a minimum, annually monitor the operation of the CCN for compliance with the provisions of this Provider Agreement, the *CCN-S Policy and Procedure Guide*, and applicable federal and state laws and regulations. Inspection shall include the CCN's facilities, as well as auditing and/or review of all records developed under this Provider Agreement including, but not limited to, periodic medical audits, grievances, enrollments, disenrollments, termination, utilization and financial records, review of the management systems and procedures developed under this Provider Agreement and any other areas or materials relevant or pertaining to this Provider Agreement.

The CCN shall have the right to review any of the findings and recommendations resulting from Provider Agreement monitoring and audits, except in the cases of fraud investigations or criminal action. However, once DHH finalizes the results of monitoring and/or audit report, the CCN must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions and/or enrollment restrictions.

12.7.1 Fee-for-Service Reporting to CCNs

DHH will be responsible for providing CCNs with a recent retrospective fee-for-service history on all current members, if available. This history will go back a maximum of twenty-four (24) months from the month of initial CCN membership. DHH's FI will post 820 files (HIPAA format equivalent of the CP-0-92) that the CCN will be able to download. The FI will keep twenty-four (24) months of rolling history available on this website. There will be NO printing/ mailing of any claims history over twenty-four (24) months.

12.7.2 Request for Corrective Action Plan

The DHH will monitor the CCN's quality care outcome activities and corrective actions taken as specified in the CCN Quality Assessment Plan in the *CCN-S Policy and Procedure Guide*.

The CCN must make provisions for prompt response to any detected deficiencies or Provider Agreement violations and for the development of corrective action initiatives relating to this Provider Agreement.

12.7.3 External Quality Review

DHH will perform periodic medical audits through contractual arrangements to determine if the CCN furnished quality and accessible health care to CCN members as described in 42 CFR 438.358. DHH may establish a contract with an External Quality Review Organization (EQRO) to perform the periodic medical audits and external independent reviews. The *CCN-S Policy and Procedure Guide* lists DHH external quality assessment evaluation requirements.

12.8 Marketing

DHH, and/or its designee shall have the right to approve, disapprove or require modification of all marketing plans, materials, and activities, enrollment and member handbook materials developed by the CCN under this Provider Agreement and prior to implementation and/or distribution by the CCN. See

§ 7 of this Provider Agreement and the *CCN-S Policy and Procedure Guide* for guidance.

12.9 Grievances

DHH shall have the right to approve, disapprove or require modification of all grievance procedures submitted with this Provider Agreement. DHH requires the CCN to meet and/or exceed the CCN grievance standards as outlined in §9 of this Provider Agreement.

12.10 Training

DHH will conduct provider training and workshops on Coordinated Care Program policy and procedures as deemed appropriate for CCNs.

12.11 Federal Fund Restrictions

The CCN is responsible to review DHH's website regarding individuals prohibited from receiving Federal funds that do not appear on the OIG electronic database but are excluded or suspended from participation in Louisiana Medicaid.

12.12 Emergency Services

DHH will cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the CCN.

DHH will not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of emergency medical condition.

DHH will not deny payment for treatment obtained when a representative of the CCN instructs the enrollee to seek emergency services.

DHH will not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms in accordance with 42 CFR §438.114(b).

DHH will not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's CCN or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services as specified in 42 CFR §438.114(b).

13 SANCTIONS AND DISPUTE RESOLUTION

13.1 Administrative Actions

It is agreed by DHH and the CCN that in the event of the CCN's failure to meet the requirements provided in this Provider Agreement, *CCN-S Policy and Procedure Guide*, *CCN-S Systems Companion*, and *Quality Performance Measure Companion Guide*. DHH may impose administrative actions/sanctions against the CCN as defined in this Provider Agreement and *CCN-S Policy and Procedure Guide*. It shall be at DHH's sole discretion as to the proper administrative sanction that will be imposed.

13.2 Corrective Action Plan (Provider Agreement Non-Compliance)

DHH will notify the CCN through Notice of Corrective Action when DHH or its designee determines that the CCN is deficient or non-compliant with requirements (excluding causes for intermediate sanctions and termination) of the Provider Agreement. The determination of deficiency and/or non-compliance with such requirements is at the sole discretion of DHH. The CCN shall submit a corrective action plan (CAP) to DHH, within the timeframe specified in the notice, for approval. The CAP shall delineate the steps and timeline for correcting deficiencies and/or non-compliance issues identified in the notice.

DHH shall impose monetary penalties and/or sanctions on the CCN for a deficient CAP. A CAP is deficient when not submitted within the Notice of Corrective Action timeline requirements; does not adequately address deficiency; and/or when the CCN and/or its contractor(s) fail to implement and/or follow the CAP.

13.3 Sanctions

13.3.1 Table of Monetary Penalties

DHH may impose monetary penalties upon the CCN for failure to timely and accurately comply with the reporting requirements and for deficient deliverables under this Provider Agreement and the *CCN-S Policy and Procedure Guide*.

For each day that each deliverable is late, incorrect or deficient, the CCN may be liable to DHH for monetary penalties in an amount per calendar day per deliverable as specified in the table below. Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Provider Agreement.

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Occurrence	Daily Amount for Days 1-14	Daily Amount for Days 15-30	Daily Amount for Days 31-60	Daily Amounts for Days 61 and Beyond
1-3	\$750	\$1,200	\$2,000	\$3,000
4-6	\$1,000	\$1,500	\$3,000	\$5,000
7-9	\$1,500	\$2,000	\$4,000	\$6,000
10-12	\$1,750	\$3,500	\$5,000	\$7,500
13 and Beyond	\$2,000	\$4,000	\$7,500	\$10,000

DHH shall utilize the following guidelines to determine whether a report is correct and complete:

1. The report must contain 100% of the CCN's data;
2. 99% of the required items for the report must be completed; and
3. 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DHH.

Monetary penalties for late reports or deliverables shall begin on the first day the report is late. Monetary penalties for incorrect reports or deficient deliverables shall begin on the sixteenth (16th) day after notice is provided from DHH to the CCN that the reports are incorrect or the deliverables are insufficient. For the purposes of determining monetary penalties in accordance with this section, reports or deliverables are due in accordance with the following schedule:

13.3.2 Monetary Penalties

In addition to the monetary penalties/fines provided in the Balance Budget Act of 1997 (P.L. 105-33), DHH may impose fines on the CCN in the amounts listed below for the following:

13.3.2.1 Key Personnel

13.3.2.1.1 Seven hundred dollars (\$700) per calendar day for failure to have a full-time acting or permanent administrator for more than seven (7) consecutive calendar days for each day following the seventh (7th) day the administrator has not been appointed.

13.3.2.1.2 Seven hundred dollars (\$700) for failure to have a

full-time acting or permanent medical director for more than seven (7) consecutive calendar days for each day following the seventh (7th) day the medical director has not been appointed.

13.3.2.1.3 Failure of the CCN to appoint a permanent full-time administrator or medical director as specified in §3 of the Provider Agreement, within forty-five days after the position(s) becomes vacant. shall result in withholding one percent (1%) of the CCN's PMPM payments for each thirty (30) days the positions are vacant.

13.3.2.1.4. Two-hundred, fifty dollars (\$250) per calendar day for each day that personnel are not licensed as required by applicable state and federal laws and/or regulations. See also §3.1.2 of this Provider Agreement.

13.3.2.2 Member Services Activities

13.3.2.2.1 Five thousand dollars (\$ 5,000) per calendar day for failure to provide access to primary care providers within the network that offer extended office hours (minimum of 2 hours) at least one day per week (after 5:00 pm) and on Saturdays [up to four (4) hours] as specified in the *CCN-S Policy and Procedure Guide*.

13.3.2.2.2 Five thousand dollars (\$ 5,000) per calendar day for failure to provide member service functions during from 7 a.m. to 7 p.m. Central Time, Monday through Friday, to address non-emergency issues encountered by members, and 24/7 to address emergency issues encountered by members as specified in the *CCN-S Policy and Procedure Guide*.

13.3.2.3 Provider Services Activities

13.3.2.3.1 Five thousand dollars (\$ 5,000) per calendar day for failure to provide for arrangements to handle emergent provider issues on a twenty-four (24)

hour, seven (7) day-a-week basis as specified in the *CCN-S Policy and Procedure Guide*.

13.3.2.3.2 Five thousand dollars (\$ 5,000) per calendar day for failure to furnish provider service functions from 7 a.m. to 7 p.m. Central Time, Monday through Friday, to address non-emergency issues encountered by providers, as specified in the *CCN-S Policy and Procedure Guide*.

13.3.2.3.3 One thousand dollars (\$1,000) per calendar day per occurrence for failure to submit a pre-processed clean claim to the FI within two (2) days of receipt of the clean claim from a provider.

13.3.2.3.4 One thousand dollars (\$1,000) per calendar day per occurrence for failure to prior authorize claims consistent with service authorization timelines at 4.4.1.

13.3.2.3.5 One thousand dollars (\$1,000) per calendar day per occurrence for failure to have a prior authorization process approved in advance by the State for the CCN-S program.

13.3.2.4 Timely Deliverables and Reports

13.3.2.4.1 Two thousand dollars (\$2,000) per report for each calendar day the Quality Assessment and Performance Improvement Plan (QAPI), performance measure, and/or performance improvement project reports are late or incorrect as outlined in the Provider Agreement, the *CCN-S Policy and Procedure Guide* and *Quality Companion Guide*.

13.3.2.4.2 Two thousand dollars (\$2,000) per day for each calendar day the member and/or provider satisfaction reports are late or incorrect as outlined in the Provider Agreement and the *CCN-S Policy and Procedure Guide*.

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13.3.2.4.3 Two thousand dollars (\$2,000) per day for each business day any other data as required by the Provider Agreement, or upon request by DHH and mutually agreed upon by the CCN, is late or incorrect.

13.3.2.4.4 One thousand dollars (\$1,000) per calendar day for each day the Patient Center Medical Home Plan is received after the due date , as specified in in the *CCN-S Policy and Procedure Guide*.

Deliverables	Date Due
Daily Reports	Within two (2) business days
Weekly Reports	Wednesday of the following week
Monthly Reports	15th of the following month with the exception of certain reports and due dates specified in the <i>CCN-S Policy and Procedure Guide</i> .
Quarterly Reports	30th of the following month after the end of the quarter.
Annual Reports	Ninety (90) calendar days after the end of the year.
On Request/ Additional Reports	Within three (3) business days from the date of request unless otherwise specified by DHH.
Corrective Action Plan	\$10,000.00 per calendar day for each day submitted following the due date; \$10,000.00 per calendar day for each day the CAP is returned as disapproved from DHH; \$10,000.00 per calendar day for each day the corrective action is not completed in accordance with the timeline established in the Corrective Action Plan.

13.3.2.5 Emergency Management Plan Submission

Ten thousand dollars (\$10,000) per calendar day for each day the Emergency Management Plan as specified in §14 of the Provider Agreement and as specified in the *CCN-S Policy and Procedure Guide* is received after the due date up to one hundred thousand dollars (\$100,000) for failure to submit timely. However, DHH may sanction an additional two hundred thousand dollars (\$200,000) for failure to submit the plan prior to the beginning of hurricane season (June 1st).

13.3.2.6 Additional Monetary Penalties

In accordance with 42 CFR §438.704, DHH may impose the following civil penalties:

- 13.3.2.6.1 Twenty-five dollars (\$25,000) for exceeding ten percent (10%) member appeals over a twelve month period which have been overturned in a State Fair Hearing; or for each occurrence in which the CCN does not provide the medical services or requirements set forth in the final outcome of the administrative decision by DHH or the appeals decision of the State Fair Hearing.
- 13.3.2.6.2 For a **nonwillful violation** as determined by DHH, the fine shall not exceed twenty-five hundred dollars (\$2,500) per violation and shall not exceed an aggregate of ten thousand dollars (\$10,000) for all nonwillful violations arising out of the same action.
- 13.3.2.6.3 For a **willful violation** as determined by DHH, DHH may impose a fine not to exceed twenty thousand dollars (\$20,000) for each violation not to exceed an aggregate of one hundred thousand dollars (\$100,000) for all knowing and willful violations arising out of the same action.

13.3.2.6.4 For purposes of this section, violations including individual, unrelated enrollees shall **not** be considered arising out of the same action.

Any monetary penalties assessed by DHH that cannot be collected through withholding from future PMPM payments shall be due and payable to DHH within thirty (30) calendar days after CCN receipt of the notice of monetary penalties. However, in the event an appeal by the CCN results in a decision in favor of the CCN, any such funds withheld by DHH will be returned to the CCN.

Whenever monetary penalties for a single occurrence exceed twenty-five thousand dollars (\$25,000), CCN staff will meet with DHH staff to discuss the causes for the occurrence and to negotiate a reasonable plan for corrective action of the occurrence. Once a corrective action plan is agreed upon by both parties, collection of monetary penalties during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for the correction of the occurrence. Should that date for correction be missed by the CCN, the original schedule of monetary penalties will be reinstated, including collection of monetary penalties for the corrective action period, and monetary penalties will continue until satisfactory correction as determined by DHH of the occurrence has been made.

At DHH's sole discretion, based on identified facts and documentation, if DHH determines that the CCN is failing to meet material obligations and performance standards described in this Provider Agreement, it may suspend CCN's right to enroll new members and impose any other sanctions in accordance with **§13** of this Provider Agreement. The DHH, when exercising this option, shall notify CCN in writing of its intent to suspend new enrollment. The suspension period may be for any length of time specified by DHH, or may be indefinite. The DHH also may notify members of the CCN of any alleged non-performance and permit these members to transfer to another CCN following the implementation of suspension.

13.3.3 Intermediate Sanctions

DHH may impose intermediate sanctions when DHH has determined that the CCN has violated any provision of this Provider Agreement

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and/or the applicable statutes or rules governing Medicaid CCNs. DHH shall provide the CCN and CMS timely written notice intent to impose sanctions and explain CCN's due process rights.

Sanctions shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §§438.700-730 and many include any of the following:

- 13.3.3.1** Suspension of payment for CCN members enrolled after the effective date of the sanction and until CMS and/or DHH is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. This violation may result in recoupment of the prepaid enhanced primary care case management payment;
- 13.3.3.2** Imposition of a fine of up to twenty-five thousand dollars (\$25,000) for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
- 13.3.3.3** Termination pursuant to **§13.3.4** of this Provider Agreement;
- 13.3.3.4** Non-renewal of the Provider Agreement pursuant to **§14.2** of this Provider Agreement;
- 13.3.3.5** Suspension of automatic-enrollment assignments;
- 13.3.3.6** Appointment of temporary management in accordance with § 1932(e)(2)(B) of SSA (42 U.S.C. 1396u-2) (2001, as amended) and 42 CFR §438.706. If the State finds that the CCN has repeatedly failed to meet substantive requirements in §1903(m) or §1932 of the Social Security Act (42 USC 1396u-2), the State must impose temporary management, grant members the right to terminate enrollment without cause and notify the affected members of their right to terminate enrollment;
- 13.3.3.7** Civil money penalties in accordance with §1932 of the Social Security Act (42USC 1396u-2);
- 13.3.3.8** Withhold up to thirty percent (30%) of a CCN's monthly PMPM payment;

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- 13.3.3.9** Permit individuals enrolled in the CCN to disenroll without cause. DHH may suspend or default all enrollment of Medicaid eligibles after the date the CMS or DHH notifies the CCN of an occurrence under §1903(m) or § 1932(e).of the Social Security Act;
- 13.3.3.10** Terminate the Provider Agreement if the CCN has failed to meet the requirements of sections 1903(m), 1905(t)(3) or 1932(e) of the Social Security Act and offer the CCN's Medicaid members an opportunity to enroll with other CCNs to allow members to receive medical assistance under the State Plan. DHH shall provide the CCN a dispute resolution conference before the DHH Undersecretary before termination occurs. This is the exclusive remedy and the Administrative Procedure Act does not apply. DHH will notify the Medicaid members enrolled in the CCN of the conference and allow the Medicaid members to disenroll, if they choose, without cause;
- 13.3.3.11** Imposition of a fine of up to twenty-five thousand dollars (\$25,000) for each occurrence of the CCN's failure to substantially provide enhanced primary care case management services that are required to be provided to a member covered under the Provider Agreement;
- 13.3.3.12** Imposition of a fine of up to fifteen thousand dollars (\$15,000) per individual not enrolled and up to a total of one hundred thousand dollars (\$100,000) per each occurrence, when the CCN acts to discriminate among members on the basis of their health status or their requirements for health care services. Such discrimination includes, but is not limited to, expulsion or refusal to re-enroll an individual, except as permitted by Title XIX, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services;
- 13.3.3.13** Imposition of a fine of up to \$25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program which is currently zero except for nominal co-pay on pharmacy for eligibles age 19 and older. DHH will deduct from the penalty the amount of overcharges and return it to the affected member(s).

- 13.3.3.14** Imposition of a fine of twenty-five thousand dollars (\$25,000) for each occurrence of failing to pay the PCP predetermined PCP care management fee, in addition to the amount PCP was not paid.
- 13.3.3.15** Imposition of sanctions as outlined in the *CCN-S Policy and Procedure Guide* if the CCN fails to comply with the Physician Incentive Plan requirements.
- 13.3.3.16** Imposition of sanctions as outlined above if the CCN misrepresents or falsifies information that it furnishes to CMS, to the State or to a member, potential member or health care provider.

Unless the duration of a sanction is specified, a sanction will remain in effect until DHH is satisfied that the basis for imposing the sanction has been corrected. DHH will notify CMS when a sanction has been lifted.

13.3.4 Violations Subject to Intermediate Sanctions

The following are non-exhaustive grounds for which intermediate sanctions may be imposed when a CCN acts or fails to act:

- 13.3.4.1** Fails substantially to authorize medically necessary services that Medicaid is required to provide, under law or under this Provider Agreement, to a member covered under the Provider Agreement;
- 13.3.4.2** Imposes on member's premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program (currently limited to nominal co-pay for pharmacy for eligibles S age 19 and older);
- 13.3.4.3** Acts to discriminate among enrollees on the basis of their health status or need for health care services;
- 13.3.4.4** Misrepresents or falsifies information that it furnishes to CMS or to DHH;
- 13.3.4.5** Misrepresents or falsifies information that it furnishes to an enrollee, potential member, or health care provider;
- 13.3.4.6** Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §§422.208 and 422.210;

13.3.4.7 Has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by DHH or that contain false or materially misleading information;

13.3.4.8 Has violated any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations (applies to PCCM).

13.3.5 Termination for Cause

13.3.5.1 Issuance of Notice of Termination

DHH may terminate the Provider Agreement when DHH determines the CCN and/or CCN's contractor(s) have failed to perform, or violates, substantive terms of the Provider Agreement and the *CCN-S Policy and Procedure Guide* or fails to meet applicable requirements in sections 1932 and 1905(t) of the Social Security Act.

DHH will provide the CCN with a timely written *Notice of Intent to Terminate (Notice)*. The *Notice* will state the nature and basis of the sanction, effective date of termination and place and time for a pre-termination hearing. The termination will be effective no less than thirty (30) calendar days from the date of the *Notice*. The CCN may, at the discretion of DHH, be allowed to correct the deficiencies within the thirty (30) calendar day notice period, unless other provisions in this section demand otherwise, prior to the issue of a Notice of Termination.

13.3.5.1.1 In accordance with 42 CFR §438.708, DHH will conduct a pre-termination hearing as outlined in the *Notice of Intent to Terminate* to provide the CCN the opportunity to contest the nature and basis of the sanction.

13.3.5.1.2 The CCN shall receive a written notice of the outcome of the pre-termination hearing, indicating decision reversal or affirmation.

13.3.5.1.3 The decision by the DHH Undersecretary is the exclusive remedy and LA R.S. 49:950-999.25, the Administrative Procedure Act, does not apply.

13.3.5.1.4 DHH will notify the Medicaid/CHIP members enrolled in the CCN, consistent with 42 CFR §438.10, of the affirming termination decision and options for receiving Medicaid services and initiate reenrollment process.

13.3.5.2 Termination Due to Serious Threat to Health of Members

DHH may terminate this Provider Agreement immediately if it is determined that actions by the CCN or its contractor(s) pose a serious threat to the health of members enrolled in the CCN. The CCN members will be given an opportunity to enroll in another CCN (if there is capacity) or move to fee-for-service.

13.3.5.3 Payment of Outstanding Monies or Collections from CCN

The CCN will be paid for any outstanding monies due less any assessed monetary penalties/penalties. If monetary penalties/ penalties exceed monies due, collection can be made from the CCN Fidelity Bond, Errors and Omissions Insurance, or any insurance policy or policies required under this Provider Agreement. The rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Provider Agreement.

13.3.5.4 Termination for CCN Insolvency, Bankruptcy, Instability of Funds

The CCN's insolvency or the filing of a petition in bankruptcy by or against the CCN shall constitute grounds for termination for cause. If DHH determines the CCN has become financially unstable, DHH will immediately terminate this Provider Agreement upon written notice to the CCN effective the close of business on the date specified.

13.2.5.4.1 Continue Services during Insolvency

The CCN shall cover continuation of services to members for the duration of any period for which payment has been made.

13.3.5.5 Termination for Ownership Violations

The CCN is subject to termination, unless the CCN can demonstrate changes of ownership or control, when:

- 13.3.5.5.1** A person with a direct or indirect ownership interest in the CCN
- 1) Has been convicted of a criminal offense under §§1128(a) and 1128(b)(1), or (3) of the Social Security Act, in accordance with 42 CFR §1002.203;
 - 2) Has had civil monetary penalties or assessment imposed under § 1128A of the Act; or
 - 3) Has been excluded from participation in Medicare or any State health care program;
 - 4) Who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549;
 - 5) Who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (4); and
 - 6) Has a direct or indirect ownership interest or any combination thereof of 5% or more, is an officer if the CCN is organized as a corporation or a partner, if it is organized as a partnership, or is an agent or a managing employee for individuals specified in 1) – 5) above.

13.3.5.5.2 The CCN has a direct or indirect substantial contractual relationship with an excluded individual or entity. “Substantial contractual relationship” is defined as any direct or indirect business transactions that amount in a single fiscal year to more than \$25,000 or 5% of the CCN’s total operating expenses, whichever is less.

13.3.5.6 Termination Due to Conversion from CCN-S Provider Type to CCN-P Provider Type

13.3.5.6.1 After a minimum of twelve months of provision of services, the CCN may terminate this Provider Agreement for cause when the CCN declares that it will convert from a CCN-Shared Savings provider type to a CCN-Prepaid provider type.

13.3.5.6.2 The CCN must provide one hundred and twenty (120) days notice to DHH of such intent and follow the requirements set forth in §13.3.4.8 below.

13.3.5.6.3 The CCN shall not be subject to the cost specified in §13.3.4.8.6 below.

13.3.5.7 Termination Due to Conversion from CCN-P Provider Type to CCN-S Provider Type

13.3.5.7.1 After a minimum of twelve months of provision of services, the CCN may terminate this Provider Agreement for cause if the CCN declares that it will convert from a CCN-Prepaid provider type to a CCN Share- provider type.

13.3.5.7.2 The CCN must provide 120 notice to DHH of such intent and follow the requirements set forth in §13.3.5.8 below.

13.3.5.8 CCN Requirements Prior to Termination for Cause

The CCN shall comply with all terms and conditions stipulated in this Provider Agreement and *CCN-S Policy and Procedure Guide* during the period prior to the effective termination date including:

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- 13.3.5.8.1** Continue to provide services under the Provider Agreement, until the termination effective date;
- 13.3.5.8.2** Within ten (10) days of the CCN's written notification to DHH of its intent to terminate its Provider Agreement, submit a termination plan to DHH for review and approval. The CCN shall make revisions to the plan as necessary or as required by DHH and will resubmit the plan to DHH for approval after each revision. Failure to submit a termination plan within ten (10) days of written notification to DHH of termination or to timely resubmit the plan after revisions may, in DHH' discretion, result in a delay of the CCN's planned termination date. Failure to submit a termination plan in the time specified in this provision may result in a withhold of fifty percent (50%) of the CCN's monthly enhanced primary care case management payment. These funds will be withheld until DHH receives the termination plan;
- 13.3.5.8.3** Remain liable and retain responsibility for all claims with dates of service through the day of termination;
- 13.3.5.8.4** Assist DHH with grievances for dates of services prior to the termination date;
- 13.3.5.8.5** Arrange for the orderly transfer of patient care and patient records to those providers who will assume members' care. For those members in a course of treatment for which a change of providers could be harmful, the CCN must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged;
- 13.3.5.8.6** Notify all members in writing about the Provider Agreement termination and the

process by which members will continue to receive medical care at least sixty (60) calendar days in advance of the effective date of termination. The CCN will be responsible for all expenses associated with member notification. DHH must approve all member notification materials in advance of distribution. ;

13.3.5.8.7 Notify all of its providers in writing about the Provider Agreement termination at least sixty (60) calendar days in advance of the effective date of termination. The CCN will be responsible for all expenses associated with provider notification. DHH must approve all provider notification materials in advance of distribution;

13.3.5.8.8 File all reports concerning the CCN's operations during the term of the Provider Agreement in the manner described in this Provider Agreement;

13.3.5.8.9 Take all actions necessary to ensure the efficient and orderly transition of participants from coverage under this Provider Agreement to coverage under any new arrangement authorized by DHH;

13.3.5.8.10 To ensure fulfillment of its obligations before and after termination, maintain the financial requirements, fidelity bonds and insurance set forth in this Provider Agreement until DHH provides the CCN written notice that all obligations of this Provider Agreement have been met;

13.3.5.8.11 Submit reports to DHH every thirty (30) calendar days detailing the CCN's progress in completing its obligations under this Provider Agreement after the termination date. The CCN, upon completion of these obligations, shall submit a final report to DHH describing how the CCN has

completed its obligations. DHH shall, within twenty (20) calendar days of receipt of this report, advise in writing whether it agrees that the CCN has met its obligations. If DHH does not agree, then the CCN shall complete the necessary tasks and submit a revised final report. This process shall continue until DHH approves the final report;

13.3.5.8.12 Take whatever other actions are required by DHH to complete this transition;

13.3.5.8.13 Be responsible for all financial costs associated with its termination, including but not limited to costs associated with changes to the enrollment broker's website and computer system and mailings by the enrollment broker to the CCN's members regarding their choice period after the termination effective date;

13.3.5.8.14 Complete the performance of such part of the Provider Agreement which shall have not been terminated under the notice of termination;

13.3.5.8.15 Take such action as may be necessary, or as DHH may direct, for the protection of property related to this Provider Agreement which is in possession of the CCN in which DHH has or may acquire an interest;

13.3.5.8.16 In the event the Provider Agreement is terminated by DHH, continue to arrange for provision of services to the members of the CCN until the effective date of termination. During this transition period, DHH shall continue to pay the applicable PMPM rate(s). Members shall be given written notice of the State's intent to terminate the Provider Agreement and shall be allowed to disenroll immediately without cause;

13.3.5.8.17 Provide all necessary assistance to DHH in transitioning members out of the CCN's plan to the extent specified in the notice of termination. Such assistance shall include, but not be limited to, the forwarding of all medical or financial records related to the CCN's activities undertaken pursuant to this Provider Agreement; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized, and pregnant members in their last four (4) weeks of pregnancy; and

The transitioning of records, whether medical or financial, related to the CCN's activities undertaken pursuant to this Provider Agreement shall be in a form usable by DHH or any party acting on behalf of DHH and shall be provided at no expense to DHH or another CCN acting on behalf of DHH.

13.3.5.8.18 Once DHH receives the notice of termination, DHH shall:

- a. Stop auto-assignment of members to the terminating plan as of the date written notification of termination is received by DHH.
- b. Review, revise and approve the CCN's termination plan and final report in accordance with the procedures outlined above.
- c. Review, revise and approve all correspondence to the CCN's members and providers prior to distribution.
- d. Cease all new member enrollments in the CCN's plan at such time as

determined by DHH. This decision shall be at the sole discretion of DHH.

Any of the above-stated requirements may be waived or altered upon written request by the CCN and written approval by DHH.

13.3.6 Other Sanctions

DHH may impose additional sanctions allowed under state statute or regulation that address areas of noncompliance. Unless the duration of a sanction is specified, a sanction will remain in effect until DHH is satisfied that the basis for imposing the sanction has been corrected. DHH will notify CMS when a sanction has been

13.3.7 Special Rules for Temporary Management

13.3.7.1 Temporary management may only be imposed by DHH if:

- a. There is continued egregious behavior by the CCN, including, but not limited to behavior that is described in 42 CFR §438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or
- b. There is substantial risk to member's health; or
- c. The sanction is necessary to ensure the health of the CCN's members while improvements are made to remedy violations under 438.700 or until there is an orderly termination or reorganization of the CCN.

13.3.7.2 DHH may impose temporary management if it finds that the CCN has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Act. DHH shall grant members the right to terminate enrollment without cause and will notify the affected members of their right to terminate enrollment. DHH will not delay imposition of temporary management to provide a hearing before imposing this sanction. In addition, the DHH will not terminate temporary management until it determines that the CCN can ensure that the sanctioned behavior will not recur.

13.4 Dispute Resolutions

Providers, including CCN's, shall have the right to dispute resolution pursuant to LA R.S. 46:107 if they are providing service, under the provisions of Titles XIX and XXI of the Social Security Act and are aggrieved by the agency action resulting in the denial, suspension or revocation of a license or the refusal to enter into, suspension of, or termination of a service agreement, or if DHH takes any action against the CCN.

For dispute resolution request related to sanctions, except for termination for cause §13.3.4, the CCN shall comply with the procedures outlined in this section and the *CCN-S Policy and Procedure Guide*.

The CCN may submit a written request for an informal meeting with the Medicaid Deputy Director over the Medicaid Coordinated Care Section; and/or a dispute resolution conference before the DHH Undersecretary to dispute the nature and basis of the sanction prior to effective sanction date stated in the notice of intent to sanction.

The CCN shall receive a written notice of the outcome of the informal meeting and/or dispute resolution conference, indicating decision reversal or affirmation.

The decision by the DHH Undersecretary is the exclusive remedy and the Administrative Procedure Act does not apply.

Effective dates of affirmed sanction will be delineated in the notice subsequent to the final determination.

In the event the CCN challenges the decision of the DHH Undersecretary, the DHH action shall not be stayed except by order of the court.

Pending final determination of any dispute over a DHH decision, the CCN shall proceed diligently with the performance of the Provider Agreement and in accordance with the direction of DHH.

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14 TERMS AND CONDITIONS

The CCN agrees to comply with all state and federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Provider Agreement, including those not specifically mentioned in this section. Any provision of this Provider Agreement which is in conflict with federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policy. Such amendment of the Provider Agreement will be effective on the effective date of the statutes, regulations, or policy statement necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The CCN may request DHH to make policy determinations required for proper performance of the services under this Provider Agreement.

14.1 Applicable Laws and Regulations

The CCN agrees to comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws and including but not limited to:

- 14.1.1** Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);
- 14.1.2** All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. 7401, et seq.) and 20 USC §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);
- 14.1.3** Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000d) and regulations issued pursuant thereto, 45 CFR part 80; In accordance with Title VI of the Civil Rights Act of 1964 (42U.S.C. 2000d et seq.) and its implementing regulation at 45 C.F.R. Part 80, the Provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement.
- 14.1.4** Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000e) in regard to employees or applicants for employment;
- 14.1.5** Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;

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- 14.1.6** The Age Discrimination Act of 1975, as amended, 42 U.S.C 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;
- 14.1.7** The Omnibus Budget Reconciliation Act of 1981, as amended, P.L.E.97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;
- 14.1.8** The Balanced Budget Act of 1997, as amended, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;
- 14.1.9** Americans with Disabilities Act, as amended, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;
- 14.1.10** Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of CCNs for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;
- 14.1.11** Drug Free Workplace Acts, S.C. Code Ann. §44-107-10 et seq. (Supp. 2000, as amended), and the Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 82,;
- 14.1.12** Title IX of the Education Amendments of 1972 regarding education programs and activities; and
- 14.1.13** The Byrd Anti-Lobbying Amendment- Contractors who apply or bid shall file the require certification that each tier will not use Federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded form tier to tier up to the recipient (45 CFR Part 3).

14.2 Non-Renewal

This Provider Agreement shall be renewed only upon mutual consent of the parties. Either party may decline to renew the Provider Agreement for any reason.

14.3 Termination Without Cause

The party initiating termination of the Provider Agreement without cause shall submit a written Notice of Intent to Terminate without cause notice to the other party by certified mail, return receipt requested, in accordance with the requirements and timeframes specified in this section. The notice shall specify the provision of this Provider Agreement allowing for termination without cause and the date on which such termination shall become effective. **Termination without cause is not subject to dispute resolution process.** The CCN shall comply with the requirements set forth in this Provider Agreement and the *CCN-S Policy and Procedure Guide*.

14.3.1 Termination under Mutual Agreement

Under mutual agreement, DHH and the CCN may terminate this Provider Agreement without cause if it is in the best interest of DHH and the CCN. Both parties will sign a Notice of Termination which shall include, the date of termination, conditions of termination, and extent to which performance of work under this Provider Agreement is terminated.

14.3.2 Termination for Convenience

DHH may terminate this Provider Agreement for convenience and without cause upon sixty (60) calendar days written notice. Said termination shall not be a breach of Provider Agreement by DHH and DHH shall not be responsible to the CCN or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

14.3.3 Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this Provider Agreement become unavailable after the effective date of this Provider Agreement, or prior to the anticipated Provider Agreement expiration date, DHH may terminate the Provider Agreement without penalty. This notification will be made in writing. Availability of funds shall be determined solely by DHH.

14.3.4 Termination by the CCN

The CCN may terminate the Provider Agreement without cause with no less than one hundred and twenty (120) calendar days advance notice to DHH. The CCN shall submit a written *Notice of Intent to Terminate* this Provider Agreement without cause to DHH by certified mail, return

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receipt requested. The one hundred and twenty (120) calendar day advance notice timeframe and the effective termination date of the Provider Agreement will be one hundred and twenty (120) calendar days following the date DHH received the notice.

The CCN shall comply with all terms and conditions stipulated in this Provider Agreement during the period prior to the Provider Agreement termination effective date including:

- 14.1.4.1** Continue to provide services under the Provider Agreement, until the termination effective date;
- 14.1.4.2** Within ten (10) days of the CCN's written notification to DHH of its intent to terminate its Provider Agreement, submit a termination plan to DHH for review and approval. The CCN shall make revisions to the plan as necessary or as required by DHH and will resubmit the plan to DHH for approval after each revision. Failure to submit a termination plan within ten (10) days of written notification to DHH of termination or to timely resubmit the plan after revisions may, in DHH' discretion, result in a delay of the CCN's planned termination date. Failure to submit a termination plan in the time specified in this provision shall result in an withhold of 25% of the CCN's monthly prepaid enhanced primary care case management fee payments. These funds will be withheld until DHH receives the termination plan;
- 14.3.4.3** Assist DHH with grievances for dates of services prior to the termination date;
- 14.3.4.4** Arrange for the orderly transfer of patient care and patient records to those providers who will assume members' care. For those members in a course of treatment for which a change of providers could be harmful, the CCN must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged;
- 14.3.4.5** Notify all members in writing about the Provider Agreement termination and the process by which members will continue to receive primary care services and care management at least sixty (60) calendar days in advance of the effective date of termination. The CCN will be responsible for all expenses associated with member notification. DHH must approve all member notification

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materials in advance of distribution. Such notice must include a description of alternatives available for obtaining services after Provider Agreement termination;

- 14.3.4.6** Notify all of its providers in writing about the Provider Agreement termination at least sixty (60) calendar days in advance of the effective date of termination. The CCN will be responsible for all expenses associated with provider notification. DHH must approve all provider notification materials in advance of distribution;
- 14.3.4.7** File all reports concerning the CCN's operations during the term of the Provider Agreement in the manner described in this Provider Agreement;
- 14.3.4.8** Take all actions necessary to ensure the efficient and orderly transition of participants from coverage under this Provider Agreement to coverage under any new arrangement authorized by DHH;
- 14.3.4.9** Ensure fulfillment of its obligations before and after termination, maintain the financial requirements, fidelity bonds and insurance set forth in this Provider Agreement until DHH provides the CCN written notice that all obligations of this Provider Agreement have been met;
- 14.3.4.10** Submit reports to DHH every thirty (30) calendar days detailing the CCN's progress in completing its obligations under this Provider Agreement after the termination date. The CCN, upon completion of these obligations, shall submit a final report to DHH describing how the CCN has completed its obligations. DHH shall, within twenty (20) calendar days of receipt of this report, advise in writing whether it agrees that the CCN has met its obligations. If DHH does not agree, then the CCN shall complete the necessary tasks and submit a revised final report. This process shall continue until DHH approves the final report;
- 14.3.4.11** Take whatever other actions are required by DHH to complete this transition;
- 14.3.4.12** Be responsible for all financial costs associated with its termination, including but not limited to costs associated with cost to DHH for re-enrollment activities including

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changes to the enrollment broker's website and computer system and mailings by the enrollment broker to the CCN's members regarding their choice period after the termination effective date and enrollment broker costs by DHH to re-enroll members to another CCN or fee-for-service;

- 14.3.4.13** Complete the performance of such part of the Provider Agreement which shall have not been terminated under the notice of termination;
- 14.3.4.14** Take such action as may be necessary, or as DHH may direct, for the protection of property related to this Provider Agreement which is in possession of the CCN in which DHH has or may acquire an interest;
- 14.3.4.15** In the event the Provider Agreement is terminated by DHH, continue to serve or arrange for provision of services to the members of the CCN until the effective date of termination. During this transition period, DHH shall continue to pay the applicable enhanced primary care case management fee payments. Members shall be given written notice of the State's intent to terminate the Provider Agreement and shall be allowed to disenroll immediately without cause;
- 14.3.4.16** Provide all necessary assistance to DHH in transitioning members out of the CCN to the extent specified in the notice of termination. Such assistance shall include, but not be limited to, the forwarding of all medical or financial records related to the CCN's activities undertaken pursuant to this Provider Agreement; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized, and pregnant members in their last four (4) weeks of pregnancy.

The transitioning of records, whether medical or financial, related to the CCN's activities undertaken pursuant to this Provider Agreement shall be in a format approved by DHH or any party acting on behalf of DHH and shall be provided at no expense to DHH or another CCN acting on behalf of DHH;

- 14.3.4.17** Promptly supplies all information necessary to DHH or its designee for reimbursement of any outstanding financial obligations at the time of termination; and

14.3.4.18 Once DHH receives the notice of termination, DHH shall:

- a. Stop auto-assignment of members to the terminating plan as of the date written notification of termination is received by DHH;
- b. Review, revise and approve the CCN's termination plan and final report in accordance with the procedures outlined above;
- c. Review, revise and approve all correspondence to the CCN's members and providers prior to distribution; and
- d. Cease all new member enrollments in the CCN at such time as determined by DHH. This decision shall be at the sole discretion of DHH.

Any of the above-stated requirements may be waived or altered upon written request by the CCN and written approval by DHH.

14.4. Effect of Termination on Business Associate HIPAA Privacy Requirements

14.4.1 Except as provided in §14.4.2 below, upon termination of this Provider Agreement, for any reason, any Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of contractors or agents of Business Associate. Business Associate shall not retain any copies of the Protected Health Information.

14.4.2 In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Upon a mutual determination that return or destruction of Protected Health Information is not feasible, Business Associate shall extend the protections of this Provider Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such Protected Health Information.

14.5 Use of Data

DHH shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the CCN resulting from this Provider Agreement.

14.6 Non-Waiver of Breach

The failure of DHH at any time to require performance by the CCN of any provision of this Provider Agreement, or the continued payment of the CCN by DHH, shall in no way affect the right of DHH to enforce any provision of this Provider Agreement; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Provider Agreement shall be waived except by the written agreement of the parties and approval of CMS, if applicable.

Waiver of any breach of any term or condition in this Provider Agreement shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Provider Agreement shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

14.7 Non-Assignability

No assignment or transfer of this Provider Agreement or of any rights hereunder by the CCN shall be valid without the prior written consent of DHH.

14.8 Legal Services

No attorney-at-law shall be engaged through use of any direct funds provided by DHH pursuant to the terms of this Provider Agreement. Further, with the exception of attorney's fees specifically authorized by state or federal law, DHH shall under no circumstances become obligated to pay an attorney's fee or the costs of legal action to the CCN. This covenant and condition shall apply to any and all suits, legal actions, and judicial appeals of whatever kind or nature to which the CCN is a party.

14.9 Venue of Actions

Any suit, action or dispute arising out of this Provider Agreement shall be interpreted under applicable Louisiana laws, except for Louisiana's conflict of law provision, in Louisiana administrative tribunals or district courts as appropriate.

14.10 Attorney's Fees

In the event that DHH shall bring suit or action to compel performance of or to recover monetary penalties for any breach of any stipulation, covenant, or condition of this Provider Agreement, the CCN shall and will pay to DHH such attorney's fees as the court may adjudge reasonable in addition to the amount of judgment and costs.

14.11 Independent Provider

It is expressly agreed that the CCN and any contractors and agents, officers, and employees of the CCN or any contractors in the performance of this Provider Agreement shall act in an independent capacity and not as officers, agents, express or implies, and/or employees of DHH or the State of Louisiana. It is further expressly agreed that this Provider Agreement shall not be construed as a partnership or joint venture between the CCN or any contractor and DHH and the State of Louisiana.

14.12 Governing Law and Place of Suit

It is mutually understood and agreed that this Provider Agreement shall be governed by the laws of the State of Louisiana except its conflict of laws provision both as to interpretation and performance. Any action at law, suit in equity, or judicial proceeding for the enforcement of this Provider Agreement or any provision thereof shall be instituted only in the courts of the State of Louisiana. Specifically any state court suit shall be filed in the 19th Judicial District as the exclusive venue for same, and any federal suit shall be filed in the Middle District for the State of Louisiana as the exclusive venue for same. This section shall not be construed as providing a right / cause of action to the CCN in any of the aforementioned Courts

14.13 Severability

If any provision of this Provider Agreement (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both DHH and CCN shall be relieved of all obligations arising under such provision. If the remainder of this Provider Agreement is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Provider Agreement should be amended or judicially interpreted as to render the fulfillment of the Provider Agreement impossible or economically infeasible, both DHH and the CCN will be discharged from further obligations created under the terms of the Provider Agreement.

14.14 Copyrights

If any copyrightable material is developed in the course of or under this Provider Agreement, DHH shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for DHH purposes.

14.15 Subsequent Conditions

The CCN shall comply with all requirements of this Provider Agreement and DHH shall have no obligation to enroll any CCN Program Members into the CCN until such time as all of said requirements have been met.

14.16 Incorporation of Schedules/Appendices

All schedules/appendices referred to in this Provider Agreement are attached hereto, are expressly made a part hereof, and are incorporated as if fully set forth herein.

14.17 Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

14.18 Safeguarding Information

The CCN shall establish written safeguards which restrict the use and disclosure of information concerning members or potential members to purposes directly connected with the performance of this Provider Agreement. The CCN's written safeguards shall:

- 14.18.1** Be comparable to those imposed upon the DHH by 42 CFR Part 431, Subpart F (2005, as amended) and La R.S. 45:56;
- 14.18.2** State that the CCN will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;
- 14.18.3** Require written authorization from the member or potential member before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 CFR § 164.508;
- 14.18.4** Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and
- 14.18.5** Specify appropriate personnel actions to sanction violators.

The CCN shall adhere to the policy and process contained in the *CCN-S Policy and Procedure Guide* for referral of cases and coordination with the DHH's Program Integrity Unit for fraud and abuse complaints regarding members and providers.

14.19 Release of Records

The CCN shall release medical records of members, as may be authorized by the member, as may be directed by authorized personnel of DHH, appropriate agencies of the State of Louisiana, or the United States Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Provider Agreement. The ownership and procedure for release of medical records shall be controlled by the Louisiana revised statutes, including but not limited to, La.R.S. 40:1299.96, La.R.S. 13:3734, and La.C.Ev. Art. 510; and the HIPAA Privacy Rule.

14.20 Fraudulent Activity

The CCN shall report to DHH any cases of suspected Medicaid fraud or abuse by its members, network providers, employees, or contractors. The CCN shall report such suspected fraud or abuse in writing as soon as practical after discovering suspected incidents. The CCN shall report the following fraud and abuse information to DHH:

- a. The number of complaints of fraud and abuse made to the CCN that warrant preliminary investigation; and
- b. For each case of suspected provider fraud and abuse that warrants a full investigation:
 - 1) the provider's name and number,
 - 2) the source of the complaint,
 - 3) the type of provider,
 - 4) the nature of the complaint,
 - 5) the approximate range of dollars involved, and
 - 6) the legal and administrative disposition of the case.

The CCN shall adhere to the policy and process contained in the *CCN-S Policy and Procedure Guide* for referral of cases and coordination with the DHH's Program Integrity Unit for fraud and abuse complaints regarding members and providers.

14.21 Integration

This Provider Agreement shall be construed to be the complete integration of all understandings between the parties hereto. The CCN also agrees to be bound by

the *CCN-S Policy and Procedure Guide* and any rules or regulations that may be promulgated. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or affect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

14.22 Hold Harmless

The CCN shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:

- 14.22.1** Any claims for damages or losses arising from services rendered by any contractor, person, or firm performing or supplying services, materials, or supplies for the CCN in connection with the performance of this Provider Agreement;
- 14.22.2** Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or legal statutes, by CCN, its agents, officers, employees, or contractors in the performance of this Provider Agreement;
- 14.22.3** Any claims for damages or losses resulting to any person or firm injured or damaged by CCN, its agents, officers, employees, or contractors by CCN's publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Provider Agreement in a manner not authorized by the Provider Agreement or by Federal or State regulations or statutes;
- 14.22.4** Any failure of the CCN, its agents, officers, employees, or contractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
- 14.22.5** Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above;
- 14.22.6** Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or their agents, officers or employees, through the intentional conduct, negligence or omission of the CCN, its agents, officers, employees or contractors.

In the event that, due to circumstances not reasonably within the control of CCN or DHH, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the CCN, DHH, or contractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of authorized services; provided, however, that so long as this Provider Agreement remains in full force and effect, the CCN shall be liable for authorizing services required in accordance with this Provider Agreement.

14.23 Hold Harmless as to the CCN Members

As a condition of participation in the Medicaid program, the CCN hereby agrees not to bill, charge, collect a deposit from, seek cost sharing or other forms of compensation, remuneration or reimbursement from, or have recourse against, CCN members, or persons acting on their behalf, for health care services which are rendered to such members by the CCN and its contractors, and which are covered benefits under the members evidence of coverage.

The CCN further agrees that the CCN member shall not be held liable for payment for authorized services furnished under a Provider Agreement, referral, or other arrangement, to the extent that those payments would be in excess of the amount that the member would owe if the CCN provided the service directly. The CCN agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by CCN and insolvency of CCN.

The CCN further agrees that this provision shall be construed to be for the benefit of CCN members of CCN, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the CCN and such members, or persons acting on their behalf.

14.24 Non-Discrimination

The CCN agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of the CCN's program or be otherwise subjected to discrimination in the performance of this Provider Agreement or in the employment practices of the CCN. The CCN shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all contracts.

14.25 Confidentiality of Information

The CCN shall assure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the CCN's performance under this Provider Agreement, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. The CCN shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Provider Agreement.

All information as to personal facts and circumstances concerning members or potential members obtained by the CCN shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DHH or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Provider Agreement.

14.26 Employment of Personnel

In all hiring or employment made possible by or resulting from this Provider Agreement, the CCN agrees that:

- (1) There shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin; and
- (2) Affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment in accordance with all state and federal laws applicable to employment of personnel.

This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The CCN further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color,

religion, sex, or national origin. All inquiries made to the CCN concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the CCN concerning employment made possible as a result of this Provider Agreement shall conform to federal, state, and local regulations.

14.27 Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Provider Agreement shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

14.28 Force Majeure

The CCN and DHH may be excused from performance under this Provider Agreement for any period they may be prevented from performance by an Act of God; strike, war, civil disturbance or court order. The CCN shall, however, be responsible for the development and implementation of an Emergency Management Plan as specified in §14.38 of this Provider Agreement.

14.29 Conflict of Interest

The CCN-S may not enter into a contract with state agency unless conflict of interest safeguards at least equal to federal safeguards (41 USC 423, section 27) are in place per State Medicaid Director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

The CCN shall comply with requirements of Physician Incentive Plans as set forth in 42 CFR § 438.6 (h) and set forth (for Medicare) in 42 CFR § 422.208 and 422.210.

14.30 Safety Precautions

DHH and HHS assume no responsibility with respect to accidents, illnesses or claims arising out of any activity performed under this Provider Agreement. The CCN shall take necessary steps to ensure or protect its members, itself, and its personnel. The CCN agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

14.31 Loss of Federal Financial Participation (FFP)

The CCN hereby agrees to be liable for any loss of FFP suffered by DHH due to the CCN's, or its contractors', failure to perform the services as required under this Provider Agreement. Payments provided for under this Provider Agreement

will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR §438.730.

14.32 HIPAA Compliance

The CCN shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH act) and the rules and regulations promulgated there under (45 CFR Parts 160, 162, and 164). The CCN shall ensure compliance with all HIPAA requirements across all systems and services related to this Provider Agreement, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

14.33 Employee Education about False Claims Recovery

If the CCN receives annual Medicaid payments of at least \$5,000,000, the CCN must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

14.34 HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in *Appendix E – HIPAA Business Associate Appendix*.

14.35 Software Reporting Requirement

All reports submitted to DHH by the CCN must be in format accessible and modifiable by the standard Microsoft Office Suite of products or in a format accepted and approved by DHH.

14.36 National Provider Identifier

The HIPAA Standard Unique Health Identifier regulations (45 CFR 162 Subparts A & D) require that all covered entities (health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

Pursuant to the HIPAA Standard Unique Health Identifier regulations (45 CFR 162 Subparts A & D), and if the provider is a covered health care provider as defined in 45 CFR §162.402, the provider agrees to disclose its National Provider Identifier (NPI) to DHH once obtained from the NPPES. Provider also agrees to

use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with DHH.

14.37 Debarment/Suspension/Exclusion

The CCN agrees to comply with all applicable provisions of 42 CFR Part 376 , pertaining to debarment and/or suspension. As a condition of enrollment, the CCN should screen all employees and contractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the CCN may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE <http://www.oig.hhs.gov/fraud/exclusions.asp> ; the Health Integrity and Protection Data Bank (HIPDB) <http://www.npdb-hipdb.hrsa.gov/index.html> and/or the Excluded Parties List Serve (EPLS) <http://www.epls.gov>.

The CCN shall conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).

14.38 Emergency Management Plan

The CCN shall submit an emergency management plan as specified in the CCN Enrollment Process (*See CCN-S Policy and Procedure Guide*) for DHH approval. The emergency management plan shall specify actions the CCN shall conduct to ensure the ongoing provision of health services in an epidemic, disaster or manmade emergency including, but not limited to, localized acts of nature, accidents, and technological and/or attack-related emergencies. Revisions to the DHH approved emergency plan shall be submitted to DHH for approval no less than 30 days prior to implementation of requested changes. The CCN shall submit annual (from the date of the most recently approved plan) certification to DHH when the emergency plan is unchanged from the previously approved plan.

14.39 Misuse of Symbols, Emblems, or Names in Reference to Medicaid

No person or CCN may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words “Medicaid,” or “Department of Health and Hospitals” or “Bureau of Health Services Financing,” unless prior written approval is obtained from DHH. Specific written authorization from DHH is required to reproduce, reprint, or distribute any DHH form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of program or DHH terms does not provide a defense. Each piece of mail or information constitutes a violation.

14.40 Offer of Gratuities

By signing this agreement, the CCN signifies that no member of, or a delegate of, Congress, nor any elected or appointed official or employee of the State of Louisiana, the Government Accountability Office, DHHS, CMS, or any other federal agency has or shall benefit financially or materially from this Provider Agreement. This Provider Agreement may be terminated by DHH if it is determined that gratuities of any kind were offered to, or received by, any officials or employees from the state, its agents, or employees.

14.41 Interest

Interest generated through investments made by the CCN under this Provider Agreement shall be the property of the CCN and shall be used at the CCN's discretion.

14.42 Interpretation Dispute Resolution Procedure

The CCN may request in writing an interpretation of the issues relating to the Provider Agreement from the Medicaid Deputy Director over the Medicaid Coordinated Care Section. In the event the CCN disputes the interpretation by Medicaid Deputy Director, the CCN shall submit a written reconsideration request to the Medicaid Director.

The CCN shall submit, within-twenty-one (21) days of said interpretation, a written request disputing the interpretation directly to the Medicaid Director. The ability to dispute an interpretation does not apply to language in the Provider Agreement that is based on federal or state statute, regulation or case law.

The Medicaid Director shall reduce the decision to writing and serve a copy to the CCN. The written decision of the Medicaid Director shall be final. The Medicaid Director will render the final decision based upon the written submission of the CCN and the Medicaid Deputy Director, unless, at the sole discretion of the Medicaid Director, the Medicaid Director allows an oral presentation by the CCN and the Medicaid Deputy Director or his/her designee. If such a presentation is allowed, the information presented will be considered in rendering the decision.

Pending final determination of any dispute over a DHH decision, the CCN shall proceed diligently with the performance of the Provider Agreement and in accordance with the direction of DHH.

14.43 Order of Precedence

In the event of any inconsistency or conflict among the document elements of this Agreement, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

1. Standard Clauses of PE-50 Enrollment Forms;
2. The body of this Agreement;
3. The appendices attached to the body of this Agreement
4. *CCN-S Policy and Procedure Guide*
5. *CCN-S Systems Companion Guide*
6. *Quality Performance Measures Companion Guide*
7. The CCN's approved:
 - a. Marketing Plan on file with DHH
 - b. Action and Grievance System Procedures on file with DHH
 - c. Quality Assurance Plan on file with DHH
 - d. ADA Compliance Plan on file with DHH
 - e. Fraud and Abuse Prevention Plan on file with DHH.

LEFT BLANK INTENTIONALLY

Provider Agreement for Coordinated Care Networks – Shared Savings

IN WITNESS WHEREOF the CCN, by its authorized agent, submits this Provider Agreement as of the first day of _____ of _____, 2010 and agrees to comply with the requirements set forth in the CCN Enrollment Process in the *CCN-S Policy and Procedure Guide*.

(Coordinated Care Network)

BY: _____

Print Name: _____

Title: _____

Witness

Witness

IN WITNESS WHEREOF the DHH, by its authorized agent, has received this Provider Agreement as of _____, 2010. Final approval of this Provider Agreement will be dependent upon the CCN passing all elements in the CCN Enrollment Process and determined “certified” to proceed as a Coordinated Care Network-Shared Savings provider.

BY: _____

Print Name: _____

Title: _____

Witness

Witness

Provider Agreement for Coordinated Care Networks – Shared Savings

IN WITNESS WHEREOF the DHH, by its authorized agent, approves this Provider Agreement as of the first day of _____ of _____, 2010 and determines the CCN to be certified and eligible to be enrolled in the Medicaid Program. Final approval of this Provider Agreement is contingent upon approval by the Center of Medicaid/Medicare Services (CMS).

BY: _____

Print Name: _____

Title: _____

Witness

Witness

Appendix A: Definitions of Terms

DEFINITIONS

The following terms, as used in this Provider Agreement, shall be construed and interpreted as follows unless the context clearly requires otherwise.

AAFP – American Academy of Family Physicians

Abuse –Related to Medicaid Program Integrity, means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Recipient practices that result in unnecessary cost to the Medicaid program are also included. 42 CFR §455.2

Action - a termination, suspension, or reduction (which includes denial of a service based on OGC interpretation of CFR 431) of Medicaid eligibility or covered services.

Adequate Network/Adequacy of Network – Refers to the network of health care providers for a CCN (whether in- or out-of-network) that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider-patient ratios for primary care providers; geographic accessibility and travel distance; waiting times for appointments and hours of provider operations.

Adverse Action – Any decision by the CCN to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested. 42 CFR §438.214(c)

Adverse Determination - An admission, availability of care, continued stay or other health care service that has been reviewed by a CCN and based upon the information provided, does not meet the CCN's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed or terminated.

Age Discrimination Act of 1975 - prohibits discrimination on the basis of age in programs and activities receiving federal financial assistance. The Act, which applies to all ages, permits the use of certain age distinctions and factors other than age that meet the Act's requirements. The Age Discrimination Act is enforced by the Civil Rights Center.

Aged/Blind/Disabled A unique eligibility category within the Medicaid Program that defines specific conditions for which a person may be determined eligible to receive Medicaid health care services. Applies to individuals who are eligible for Medicaid due to blindness or disability.

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Agent - Any person or entity with delegated authority to obligate or act on behalf of another party.

Ambulatory Care - Preventive, diagnostic and treatment services provided on an outpatient basis.

Americans with Disabilities Act of 1990 (ADA) - The Americans with Disabilities act prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications and governmental activities. The ADA also establishes requirements for telecommunications relay services.

Appeal - A request for a review of an action pursuant to 42 CFR §438.400(b).

Appeal Procedure - A formal process whereby a member has the right to contest an adverse determination/action rendered by a CCN, which results in the denial, reduction, suspension, termination or delay of health care benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Automatic Assignment - The process utilized to enroll into a CNN, using predetermined algorithms, a Medicaid/CHIP eligible who 1) is not excluded from CCN participation and 2) does not proactively select a CCN within the DHH specified timeframe.

Behavioral Health Services (BHS) - Mental health and substance abuse services, which are provided to enrollees with emotional, psychological, substance abuse, psychiatric symptoms and/or disorders. Basic behavioral health services are provided in the enrollee's PCP office by the enrollee's PCP as part of primary care service activities as well as those services provided in an FQHC. Specialized mental health services shall include, but not be limited to, services specifically defined in state plan and provided by a psychiatrist, psychologist, and/or mental health rehabilitation provider to those enrollees with a primary diagnosis of a behavioral disorder.

Benefits or Covered Services - Those health care services to which an eligible Medicaid/CHIP recipient is entitled under Louisiana Medicaid State Plan.

Board Certified - An individual who has successfully completed all prerequisites of a respective medical specialty board and has successfully passed the required examination for certification.

Bureau of Health Services Financing (BHSF) - The agency within the Louisiana Department of Health & Hospitals, Office of Management & Finance that has been designated as Louisiana's single state Medicaid agency to administer the Medicaid and CHIP programs.

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Business Day – Traditional workdays, including Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded and traditional work hours of 8:00 a.m. – 5:00 p.m.

CAHPS - The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of members' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality (AHRQ).

Calendar Days – All seven (7) days of the week. Unless otherwise specified, the term “days” in this *Guide* refers to calendar days.

Care Coordination – Deliberate organization of patient care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in the member's care to facilitate care within the network with services provided by non-network providers to ensure appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of member's care.

Care Management - Overall system of medical management encompassing Utilization Management, Referral, Case Management, Care Coordination, Continuity of Care and Transition Care, Chronic Care Management, Quality Care Management, and Independent Review.

Case Management – Refers to a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services including medical, social, educational, and other support services. Case Management services include an individual needs assessment and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and monitoring outcomes.

Cause – Specified reasons that allow mandatorily enrolled CCN members to change their CCN choice. Term may also be referred to as “good cause.”

CCN-S Policy and Procedure Guide – The policy and procedure guide for Prepaid Coordinated Care Networks and their providers.

Centers for Disease Control/Advisory Committee on Immunization Practices (CDC/ACIP) Federal agency and committee whose role is to provide advice that will lead to a reduction in the incidence of vaccine-preventable diseases in the United States and an increase in the safe use of vaccines and related biological products.

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Centers for Medicare and Medicaid Services (CMS) - The agency within the United States Department of Health & Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. Formerly known as Health Care Financing Administration (HCFA)

Certified Nurse Midwife (CNM) - An advanced practice registered nurse educated in the disciplines of nursing and midwifery and certified according to a nationally recognized certifying body, such as the American College of Nurse Midwives Certification Council, as approved by the state board of nursing and who is authorized to manage the nurse midwifery care of newborns and women in the ante-partum, intra-partum, postpartum, and/or gynecological periods.

CFR - Code of Federal Regulations.

CHIP - Children's Health Insurance Program created in 1997 by Title XXI of the Social Security Act. Known in Louisiana as LaCHIP

Chisholm Class Members - All current and future recipients of Medicaid in the state of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry.

Choice Counseling - Enrollment Broker activities such as answering questions and providing information in an unbiased manner on available CCNs and advising potential enrollees/enrollees on what factors to consider when choosing among them.

Chronic Care Management Program (CCMP) - A system of coordinated health care in which interventions and communications for populations with conditions in which patient self-care efforts are significant. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

Chronic Care Management - The concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care.

Claim - A request for payment for benefits received or services rendered.

Clean Claim - A claim that has no defect or impropriety, including any lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment of the claim from being made. It does not include a claim from a

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provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

CMS 1500 - Universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-92.

Cold Call Marketing - Any unsolicited personal contact with a Medicaid eligible individual by the CCN, its staff, its volunteers or its vendors/contractors with the purpose of influencing the Medicaid eligible individual to enroll in the CCN or either to not enroll in or disenroll from another CCN.

CommunityCARE - Refers to the Louisiana Medicaid Primary Care Case Management (PCCM) program which links Medicaid/CHIP eligibles to a primary care provider as their medical home.

Co-payment - Any cost sharing payment for which the Medicaid/CHIP CCN member is responsible, in accordance with 42 CFR, § 447.50 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) for Native American members.

Coordinated Care Network (CCN) - An entity designed to improve performance and health outcomes through the creation of cost effective integrated healthcare delivery system that provides a continuum of evidence-based, quality-driven healthcare services for Medicaid/CHIP eligibles.

Coordinated Care Network - Prepaid (CCN-P) - A prepaid entity that participates in the Louisiana Medicaid Program, referred to in the Provider Agreement as a Coordinated Care Network- Prepaid. The entity is regulated by the Louisiana Department of Insurance with respect to licensure and financial solvency pursuant to Title 22 of the Louisiana Revised Statutes, but shall, solely with respect to its products and services offered pursuant to the Louisiana Medicaid Program be regulated by the Louisiana Department of Health and Hospitals.

Coordinated Care Network - Shared Savings (CCN-S) - An entity that provides enhanced primary care case management services that include primary care provider (PCPs) care management services. The CCN-S expands the roles and responsibilities of the primary care providers through the establishment of patient-centered medical homes; and creation of a formal and distinct network of primary care providers to coordinate the full continuum of care while achieving budget and performance goals and benchmarks.

Contract - An agreement between a CCN and a provider of services to furnish core benefits and services to members, or with a marketing organization, or with any other organization or

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person who agrees to perform any administrative function or service for the CCN specifically related to fulfilling the CCN's obligations under the terms of this agreement.

Contract Dispute - A circumstance whereby the CCN and their contractor are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under the contract.

Contractor - A person, agency or organization with which a CCN has contracted or delegated some of its management functions or other contractual responsibilities to provide covered services to its members.

Convicted - A judgment of conviction entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.

Corrective Action Plan (CAP) - A plan developed by the Coordinated Care Network that is designed to ameliorate an identified deficiency and prevent reoccurrence of that deficiency. The CAP outlines all steps/actions and timeframe necessary to address and resolve the deficiency.

Cost Neutral - The mechanism used to smooth data, share risk, or adjust for risk that will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

Covered Services - Those health care services/benefits to which an individual eligible for Medicaid/CHIP is entitled under the Louisiana Medicaid State Plan.

CPT® - Current Procedural Terminology, Fourth edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. DHHS designated the CPT code set as the national coding standard for physician and other health care professional services and procedures under HIPAA.

Department (DHH) - The Louisiana Department of Health and Hospitals, referred to as DHH throughout this Provider Agreement.

Department of Health and Human Services (DHHS; also HHS) - The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The DHHS includes more than 300 programs, covering a wide spectrum of activities, including medical and social science research; preventing outbreak of infectious disease; assuring food and drug safety; overseeing Medicare, Medicaid and CHIP; and providing financial assistance for low-income families.

Disease Management (DM) - see Chronic Care Management

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Disenrollment - Action taken by DHH or its designee to remove a Medicaid/CHIP CCN member from the CCN following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid/CHIP or the CCN Program

Durable Medical Equipment , Prosthetics, Orthotics, and certain Supplies (DMEPOS) - DME is inclusive of equipment which 1) can withstand repeated use, 2) is primarily and customarily used to serve a medical purpose; 3) generally is not useful to a person in the absence of illness or injury, and 4) is appropriate for use in the home. POS is inclusive of prosthetics, orthotics and certain supplies. Certain supplies are those medical supplies that are expendable in nature, such as catheters and diapers.

Direct Marketing/Cold Call - Any unsolicited personal contact with or solicitation of a Medicaid/CHIP eligible in person, through direct mail advertising or telemarketing by an employee or agent of the CCN for the purpose of influencing an individual to enroll with the CCN.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - A federally required Medicaid benefit for individuals under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of 1) screening and diagnostic services to determine physical or mental defects and 2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered (CFR 440.40 (b)). EPSDT requirements help to ensure access to all medically necessary health services within the federal definition of “medical assistance”.

E-Consultation - The use of electronic computing and communication technologies in consultation processes.

Electronic Health Records (EHR) - A computer-based record containing health care information. This technology, when fully developed, meets provider needs for real-time data access and evaluation in medical care. Implementation of EMR increases the potential for more efficient care, speedier communication among providers and management of CCNs.

Eligibility Determination - The process for which an individual may be determined eligible for the Medicaid or Medicaid-expansion CHIP program.

Eligible - An individual determined eligible for assistance in accordance with the Medicaid State Plan(s) under the Title XIX or Title XXI of the Social Security Act.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate

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medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part..

Emergency Services - Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 CFR 438.114(a) and 1932(b)(2) and that are needed to screen, evaluate, and stabilize an emergency medical condition. Services defined as such under Section 1867 (e) of the Social Security Act (“anti-dumping provisions”).

Enrollee -

Enrollment - -The process conducted by the Enrollment Broker by which an eligible Medicaid/CHIP recipient becomes a member of a CCN.

Enrollment Broker - The state’s contracted or designated agent that performs functions related to outreach, education, choice counseling, enrollment and disenrollment of potential enrollees into a CCN.

Evidence-Based Practice - Clinical interventions that have demonstrated positive outcomes in several research studies to assist consumers in achieving their desired goals of health and wellness.

Excluded Populations - Medicaid eligibles that are excluded from enrollment in a CCN and may not voluntarily enroll.

External Quality Review Organization (EQRO) – an organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs EQR and other related activities as set forth in federal regulations, or both.

Experimental Procedure/Service - A procedure or service that requires additional research to determine safety, effectiveness, and benefit compared to standard practices and characteristics of patients most likely to benefit. The available clinical scientific data may be relatively weak or inconclusive. The term applies only to the determination of eligibility for coverage or payment.

Family Planning Services - Services that include examinations and assessments, diagnostic procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

Federal Financial Participation (FFP) - Also known as Federal Match, the percentage of Federal matching dollars available to a state to provide Medicaid and CHIP services. The Federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula designed to provide a higher Federal matching rate to States with lower per capital income.

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Federally Qualified Health Center (FQHC) - An entity that receives a grant under Section 330 of the Public Health Service Act, as amended (Also see Section 1905(1)(2)(B) of the Social Security Act) to provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

Fee for Service (FFS) - A method of provider reimbursement based on payments for specific services rendered to an individual enrolled in Louisiana Medicaid.

FFS Provider - An institution, facility, agency, person, corporation, partnership, or association approved by DHH which accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Fiscal Intermediary (FI) - DHH's designee or agent responsible in the current delivery model for an array of support services including MMIS development and support, claims processing, pharmacy support services, provider support services, financial and accounting systems, prior authorization and utilization management, fraud and abuse systems, and decision support.

Fiscal Year (FY) - Refer to budget year - Federal Fiscal Year: October 1 through September 30 (FFY); State Fiscal Year (SFY): July 1 through June 30.

Fraud - As relates to the Medicaid Program Integrity, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.

Full-Time Equivalent Position (FTE) - Refers to the equivalent of one (1) individual full-time employee who works forty (40) hours per week; or a full-time primary care physician shall be defined as a physician delivering outpatient preventive and primary (routine, urgent and acute) care for thirty-two (32) hours or more per week (exclusive of travel time) for a minimum of four (4) days per week.

GEO Coding - Refers to the process in which implicit geographic data is converted into explicit or map-form images.

GEO Mapping - The process of finding associated geographic coordinates (often expressed as latitude and longitude) from other geographic data, such as street addresses, or zip codes (postal codes). With geographic coordinates the features can be mapped and entered into Geographic Information Systems, or the coordinates can be embedded into media.

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Geographic Service Area - The designated geographical service area in which the CCN is authorized by the Provider Agreement to deliver core benefits and services to Medicaid/CHIP enrollees. The minimum geographic service area a CCN may provide core benefits shall be one parish. See Service Area.

Go-Live Date - The date the CCN shall begin providing services to Medicaid/CHIP members.

Good Cause - see “cause”.

Grievance - An expression of member/provider dissatisfaction about any matter other than an action, as action is defined. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Health Care Financing Administration (HCFA) - Prior to 2001, the name for the federal agency within the Department of Health and Human Services that is responsible for the administration of the Medicaid and CHIP programs. In 2001 the name was changed to Centers for Medicare and Medicaid Services (CMS)

Health Care Professional - A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Health Care Provider - a health care professional or entity who provides health care services or goods.

Healthcare Effectiveness Data and Information Set (HEDIS) - A set of performance measures developed by the National Committee for Quality Assurance (NCQA). The measures were designed to help health care purchasers understand the value of health care purchases and measure plan (e.g. CCN) performance.

HIPAA - (Health Information Portability Administration Act) -

Holistic- Practice approach that takes into account the physical, emotional, social, economic, and spiritual needs of the member, their response to their illnesses, and the effect of illness on the members’ abilities to meet self-care needs, promoting a multidisciplinary model of care.

Home and Community Based Services Waiver (HCBS) - Under Section 1915 (c) of the Social Security Act States may request waivers of state wideness, comparability of services, and community income and resource rules for the medically needy in order to develop Medicaid-financed community-based treatment alternatives. Non-state plan services that may be offered include case management, homemaker/home health aide services, personal care services, adult day health, habilitation, and respite care. Current HCBS waivers in Louisiana are New

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Opportunities Waiver (NOW), Children’s Choice, Elderly and Disabled Adult Waiver, Adult Day Health Care, Supports Waiver, Adult Residential Options.

Hospice - Services provided under fee-for-service as described in Louisiana Medicaid State Plan and 42 CFR §418, which are provided to terminally ill individuals, with a prognosis of 6 months or less, who elect to receive hospice services provided by a certified hospice agency.

ICD-9-CM codes -**International Classification of Diseases, 9th Revision, Clinical Modification** codes represent a uniform, international classification system of coding disease and injury diagnoses. This coding system arranges diseases and injuries into code categories according to established criteria.

Immediate - In an immediate manner; instant; instantly or without delay.

Implementation Date - The date the CCN’s Provider Agreement has been approved to proceed to DHH’s on-site Readiness Review process. It differs from the service start-up or “go live” date (which should be roughly five months from the implementation date). At implementation, a CCN can begin the process of establishing all systems for the subsequent enrollment of Medicaid eligibles and service start-up date and preparing for the DHH’s Readiness Review. Enrollment of members will not begin until the CCN has passed the CCN Enrollment Process or at the “go live” date.

Incentive Arrangement -Any payment mechanism under which a contractor may receive additional funds over and above the rate it was paid for meeting targets specified in the contract.

Individual Practice - Independent physicians who work in their own private practices.

Information Systems (IS) - A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, *i.e.* structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Insolvency - A financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business, or when the liabilities of the entity exceed its assets, or as determined by the Louisiana Department of Insurance pursuant to Title 22 of the Louisiana Revised Statutes.

Institutionalized - A patient in a nursing facility; an in-patient in a medical institution or institution for mental disease, whereby payment is based on a level of care provided in a nursing facility; or receives home and community-based waiver services.

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Investigational Procedure/Service – see Experimental Procedure/Service.

Kick Payment - The method of reimbursing prepaid CCNs in the form of a separate one (1) time fixed payment for specific services in addition to the PMPM payment.

KIDMED - Louisiana's screening component for Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) program provided for Medicaid/CHIP eligible children under the age of 21. Required by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89).

LaCHIP – Refers to the Louisiana's Medicaid expansion CHIP (Title XXI) Program that provides health coverage to uninsured children under age 19, whose families have a net income up to 200 percent of the Federal Poverty Level (FPL); and whose income exceeds the Medicaid limit. Phase 1 includes children ages 6-18 with income from 100% up to and including 133% FPL; Phase II includes children with income from 134% up to and including 150% FPL; Phase 3 includes children with income from 151% FPL up to and including 200% FPL.

LaCHIP Prenatal Program (Phase IV) – Louisiana's separate CHIP (Title XXI) program which provides prenatal coverage through the Medicaid delivery system from conception to birth for children whose uninsured mothers are ineligible for Medicaid and have net family income at or below 200%.

LaCHIP Affordable Plan (Phase V) – Louisiana's separate state CHIP (Title XXI) program that provides health coverage to uninsured children in families with income from 201% up to and including 250% FPL. The program is administered by the Louisiana Office of Group Benefits.

LaMOMS - Medicaid program for pregnant women with income up to and including 133% FPL and optional Medicaid program for pregnant women with income from 134% up to and including 185% FPL. With a 15% income disregard, the income limit is in effect, 200% FPL. The program provides pregnancy-related services, delivery and post-partum care for 60 days after the pregnancy ends for women whose sole basis of eligibility is pregnancy

Louisiana Children's Health Insurance Program (LaCHIP) – Louisiana's name for the Children's Health Insurance Plan created by Title XXI of the Social Security Act in 1997. Provides health care coverage for uninsured children up to age 19 through a Medicaid expansion program for children at or below 200% FPL and a separate state CHIP program for the unborn prenatal option and for children with income from 200% up to and including 250% FPL.

Louisiana Department of Health and Hospitals (DHH) – The state department responsible for promoting and protecting health and ensuring access to medical, preventive and rehabilitative services for all citizens in the state of Louisiana.

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Louisiana Medicaid State Plan - The binding written agreement DHH and CMS which describes how the Medicaid program is administered and determines the services DHH will receive federal financial participation.

Mandatory Population/Eligible - The categories of eligible Medicaid/CHIP eligibles who are required to enroll in a Medicaid CCN and whose participation is not voluntary.

Marketing means any communication, from an CCN to a Medicaid/CHIP eligible who is not enrolled in that CCN, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular CCN's Medicaid product, or either to not enroll in, or to disenroll from, another CCN's Medicaid product.

Marketing Materials - Information produced in any medium, by or on behalf of a CCN that can reasonably be interpreted as intended to market to potential enrollees or members.

Mass Media - A method of public advertising that can create CCN name recognition among a large number of Medicaid/CHIP recipients and can assist in educating them about potential health care choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters, and video in doctor's office waiting rooms.

Material Change - Material changes are changes affecting the delivery of care or services provided under this Provider Agreement. Material changes include, but are not limited to, changes in: composition of the provider network, contractor network, CCN's complaint and grievance procedures; health care delivery systems, services, changes to expanded services; benefits; geographic service area; enrollment of a new population; procedures for obtaining access to or approval for health care services; any and all policies and procedures that required DHH approval prior to implementation; and the CCN's capacity to meet minimum enrollment levels. DHH shall make the final determination as to whether a change is material.

Medicaid - A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.

Medicaid Eligibility Office - The Department of Health and Hospital's offices located within select parishes of the state and State Office that are responsible for initial and ongoing financial eligibility determination.

Medicaid/CHIP Eligible - Refers to an individual determined eligible, pursuant to federal and state law, to receive medical care, goods and services for which DHH may make payments under the Medicaid or CHIP Programs, who is enrolled in the Medicaid or CHIP Program, and on whose behalf payments may or may not have been made.

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Medicaid Library - A repository of manuals, statutes, rules and other reference material referred to in this Provider Agreement located in DHH's Administrative Offices in the Bienville Building, Baton Rouge, Louisiana or in electronic format and accessible at www.MakingMedicaidBetter.com

Medicaid/CHIP Recipient - An individual who has been determined eligible, pursuant to federal and state law, to receive medical care, goods or services for which DHH may make payments under the Medicaid or CHIP Program, who may or may not be currently enrolled in the Medicaid or CHIP Program, and on whose behalf payment is made.

Medicaid FFS Provider - An institution, facility, agency, person, corporation, partnership, or association that has signed a PE 50 agreement, been approved by DHH, and accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

Medical Home - Systems of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, nursing homes and home health agencies. Primary care providers are inclusive of physician-led and nurse-practitioner-led primary care practices.

Medical Necessity Review Organization (MNRO) - A health insurance issuer or other entity licensed or authorized pursuant to La RS 22:1122 to make medical necessity determinations for purposes other than the diagnosis and treatment of a medical condition.

Medical Record - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical health care services whether provided by the CCN, its contractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR §456.111 and 42 CFR §456.211.

Medical Vendor Administration (MVA) - Refers to the name for the budget unit specified in the Louisiana state budget which contains the administrative component of the Bureau of Health Services Financing (Louisiana's single state Medicaid agency).

Medically Necessary Services - Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) not more costly than an alternative service or sequence of services at least as like to produce equivalent

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therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.

Medicare - The federal medical assistance program in the United States authorized in 1965 by Title XVIII of the Social Security Act, to address the medical needs. Medicare is available to U.S. citizens 65 years of age and older and some people with disabilities under age 65.

Member - As it relates to the Louisiana Medicaid/CHIP Program and this Provider Agreement refers to a Medicaid/CHIP eligible who enrolls in a CCN under the provisions of this agreement) and also refers to "enrollee" as defined in 42 CFR § 438.10(a).

Member Month - A month of coverage for a Medicaid/CHIP eligible who is enrolled in the CCN.

Medicaid Management Information System (MMIS) - Mechanized claims processing and information retrieval system which all states Medicaid programs are required to have and which must be approved by the Secretary of DHHS. This system is an organized method of payment for claims for all Medicaid services and includes information on all Medicaid Providers and Eligibles.

Monetary Penalties - Monetary sanctions that may be assessed whenever a CCN, its providers, and/or its contractors fail to achieve certain performance standards and other items defined in the terms and conditions of the provider agreement.

National Response Framework - Part of the Federal Emergency Management Agency (FEMA), The National Response Framework presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies. The framework establishes a comprehensive, national, all-hazards approach to domestic incident response.

National Committee for Quality Assurance (NCQA) - A not-for-profit organization that performs quality-oriented accreditation reviews on health maintenance organizations and similar types of managed care plans.

Network - As utilized in the Provider Agreement, "network" may be defined as a group of participating providers linked through contractual arrangements to a CCN to supply a range of primary and acute health care services. Also referred to as Provider Network.

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Network Adequacy - Refers to the network of health care providers for a CCN (whether in- or out-of-network) that is sufficient in numbers and types of providers and facilities to ensure that all services are accessible to members without unreasonable delay. Adequacy is determined by a number of factors, including but not limited to, provider/patient ratios; geographic accessibility and travel distance; waiting times for appointments and hours of provider operations.

Non-Contracting Provider - A person or entity that provides hospital or medical care but does not have a contract or contract with the CCN.

Newborn - A live infant born to a CCN member.

Non-Covered Services - Services not covered under the Title XIX Louisiana State Medicaid Plan.

Non-Emergency - An encounter by a CCN member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.

Non-Participating Physician - A physician licensed to practice that has not contracted with or is not employed by the CCN to provide health care services.

Non-Urgent Sick Care - Medical care given for an acute onset of symptoms that is not emergent or urgent in nature. Examples of non-urgent sick visit include cold symptoms, sore throat, and nasal congestion; requires face-to-face medical attention within 72 hours of member notification of a non-urgent condition, as clinically indicated.

Nurse Practitioner (NP)- An advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency such as the American Nurses Association's American Nurses Credentialing Center, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, or the National Certification Board of Pediatric Nurse Practitioners and Nurses, or as approved by the state board of nursing and who is authorized to provide primary, acute, or chronic care, as an advanced nurse practitioner acting within his/her scope of practice to individuals, families, and other groups in a variety of settings including, but not limited to, homes, institutions, offices, industry, schools, and other community agencies.

Open Enrollment - The period of time when a CCN member may change CCNs without cause (*once per year after initial enrollment*).

Ownership Interest - The possession of stock, equity in the capital, or any interest in the profits of the CCN, for further definition see 42 CFR 455.101 (2005).

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Per Capita Prepaid Benchmark (PCPB, the benchmark) – The projected medical costs of the CCN-s member for the evaluation period. The benchmark will be risk-adjusted based upon the health risk associated with the CCN-S membership. The risk-adjusted benchmark is compared to the sum of actual cost and paid enhanced primary care case management fees to determine if shavings have been achieved.

Per Member Per Month (PMPM) – The amount of money paid or received on a monthly basis for each individual enrolled.

Performance Improvement Projects (PIP) – Projects to improve specific quality Performance Measures through ongoing measurements and interventions that result in significant improvement, sustained over time, with favorable effect on health outcomes and member satisfaction.

Performance Measures – Specific operationally defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement related important dimensions of care and service.

Personal Health Record (PHR) – A health record that is initiated and maintained by an individual.

Physician Assistant – A health care professional who is a graduate of a program accredited by the Committee on Allied Health Education and Accreditation or its successors and who has successfully passed the national certificate examination administered by the National Commission on the Certification of Physicians’ Assistants or its predecessors and who is approved and licensed by the Louisiana State Board of Medical Examiners to perform medical services under the supervision of a physician or group of physicians who are licensed and registered with the board to supervise such assistant. A physician assistant may perform certain duties such as history taking, diagnosis, drawing blood samples, urinalysis, and injections under the supervision of a physician.

Physician Extender – Nurse practitioners, certified nurse mid-wives, and physician assistants linked to a physician group who provide primary care services.

Physician Practice Connections®Patient-Center Medical Home (PPC-PCMH™) – NCQA recognition for physician practices that meet specific criteria for medical homes.

Plan of Care – Strategies designed to *Guide* health care professionals involved with patient care. Such plans are patient specific and are meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care.

PMPM Rate – The per-member, per-month rate paid to the CCN for the provision of enhanced primary care case management services to CCN members.

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Policies - The general principles by which DHH is *Guided* in its management of the Title XIX program, and as further defined by DHH promulgations and by state federal rules and regulations.

Potential Enrollee - A Medicaid/CHIP eligible who is subject to mandatory enrollment or may voluntarily elect to enroll in a CCN, but is not yet an enrollee of a specific CCN.

Poverty Level - Poverty guidelines issued annually in late January or early February by the Department of Health & Human Services for the purpose of determining financial eligibility for certain programs including Medicaid and CHIP and which are based on household size. Guidelines are updated from the Census Bureau's latest published weighted average poverty thresholds.

Preventive Care - Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred; requires a face-to-face visit within 4 weeks of member request

Primary Care Services- Health care services and laboratory services customarily furnished by or through a primary care provider for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through, direct service to the member when possible, or through appropriate referral to specialists and/or ancillary providers.

Primary Care Case Management - A system under which a PCCM contracts with the state to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid/CHIP recipients.

Primary Care Case Manager (PCCM) - A physician, physician group practice, or entity that employs or arranges with physicians to furnish primary care case management services.

Primary Care Provider (PCP) - An individual physician or other licensed nurse practitioner responsible for the management of a member's health care who is licensed and certified in one of the following general specialties; family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/ gynecologist. The primary care provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist (secondary/tertiary care), or admit the patient to a hospital.

Prior Authorization - The process of determining medical necessity for specific services before they are rendered.

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Privacy Rule (45 CFR Parts 160 & 164) - Standards for the privacy of individually identifiable health information.

Prospective Review - Utilization review conducted prior to an admission or a course of treatment.

Protected Health Information (PHI) - Individually identifiable health that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Part 160 and 164

Provider Agreement - As it pertains to CCNs, the Model Provider Agreement document(s) signed by or on behalf of the CCN entity and those things established or provided for in R.S. 46:437.11-437.14 or by rule, which enrolls the entity in the Medical Assistance Program and grants to the entity provider number and the privilege to participate in the CCN program. It includes the signed Model Provider Agreement document, together with any and all future addendums issued thereto by DHH.

Provider - Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the CCN Program, any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

Quality - As it pertains to external quality review means the degree to which a CCN increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assessment and Performance Improvement Program (QAPI Program) - Program that objectively and systematically defines, monitors and evaluates the quality and appropriateness of care and services and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities.

Quality Assessment and Improvement (QAPI) Plan - A written plan, required of all CCNs, detailing quality management and committee structure, performance measures, monitoring and evaluation process and improvement activities measures that rely upon quality monitoring implemented to improve health care outcomes for enrollees.

Quality Management (QM) - The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical and behavioral health knowledge.

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Readiness Review - Refers to DHH's assessment of the CCN's ability to fulfill the Provider Agreement requirements. Such review may include but not be limited to review of proper licensure; operational protocols, review of CCN standards; and review of systems. The review may be done as a desk review, on-site review, or combination and may include interviews with pertinent personnel so that DHH can make an informed assessment of the CCN's ability and readiness to render services.

Recipient - An individual entitled to benefits under Title XIX or Title XXI of the Social Security Act, and under the Louisiana Medicaid State Plan who is or was enrolled in Medicaid/CHIP and on whose behalf a payment has been made for medical services rendered.

Registered Nurse (RN) - Person licensed as a Registered Nurse by the Louisiana State Board of Nursing.

Referral Services - Health care services provided to CCN members to both in- and out-of-network when ordered and approved by the CCN, including, but not limited to in-network specialty care and out-of-network services which are covered under the Medicaid program and reimbursed at the Fee-For-Service Medicaid Rate.

Related Party - A party that has, or may have, the ability to control or significantly influence a contractor, or a party that is, or may be, controlled or significantly influenced by a contractor. "Related parties" include, but are not limited to, agents, management employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, contractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

Relationship - Relationship is described as follows for the purposes of any business affiliations discussed in § 5: A director, officer, or partner of the CCN; A person with beneficial ownership of five percent or more of the CCN's equity; or A person with an employment, consulting or other arrangement (e.g., providers) with the CCN obligations under its contract with the State.

Remittance Advice - An electronic listing of transactions for which payment is calculated. Hard copies are available upon request only.

Representative - Any person who has been delegated the authority to obligate or act on behalf of another. Also known as the authorized representative.

Risk - The chance or possibility of loss. The member is at risk only for pharmacy copayments as allowed in the Medicaid State Plan and the cost of non-covered services. The CCN, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Risk Adjustment - A method that accounts for variation in health risks among participating CCNs when determining per capita prepaid benchmark (PCPB).

Routine Care - Treatment of a condition which would have no adverse effects if not treated within 24 hours or that could be treated in a less acute setting (e.g., physician's office) or by the patient.

Routine Primary Care - Routine primary care services include the diagnosis and treatment of conditions to prevent deterioration to a more severe level, or minimize/reduce risk of development of chronic illness or the need from more complex treatment. Examples include psoriasis, chronic low back pain; requires a face-to-face visit within 4 weeks of member request.

Rural Area - Refers to any geographic service area defined by the Office of Management and Budget definition of rural. See Appendix F of the *CCN-S Policy and Procedure Guide* for map of Louisiana Rural Parishes)

Rural Health Clinic (RHC) - A clinic located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on prospective payment system.

School Based Health Center (SBHC) - A health care provider certified by the Office of Public Health that is physically located in a school or on or near school grounds that provide convenient access to comprehensive, primary and preventive physical and mental health services for public school students.

Scope of Services - see “covered services”

Second Opinion - Subsequent to an initial medical opinion, an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

Secondary Care - Health care services provided by medical specialists who generally do not have first contact with patients, but instead are referred to them by primary care providers.

Section 1931- Category of Medicaid eligibility for low-income parents who do not receive cash assistance but whose income is below Louisiana’s 1996 Aid to Families with Dependent Children income threshold. Louisiana’s name for this program is Low Income Families with Children (LIFC)

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Secure File Transfer Protocol (SFTP) – Software protocol for transferring data files from one computer to another with added encryption.

Security Rule (45 CFR Parts 160 & 164) –Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of their Electronic Protected Health Information against any reasonably anticipated risks.

Service Area – The designated geographical area within which the CCN is authorized by the agreement to furnish covered services to enrollees. A service area shall not be less than one entire parish. Also referred to as geographic service area.

Service Authorization – A Utilization Management activity that includes pre-, concurrent, or post review of a service by a qualified health professional to authorize, partially deny, or deny the payment of a service. Service authorization activities consistently apply review criteria.

Shall - Denotes a mandatory requirement.

Should- Denotes a preference but not a mandatory requirement.

Significant – As utilized in this Provider Agreement, except where specifically defined, shall mean important in effect or meaning.

Social Security Act - The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).

Solvency- The minimum standard of financial health for a CCN where assets exceed liabilities and timely payment requirements can be met.

Span of Control – Information systems and telecommunications capabilities that the CCN itself operates or for which it is otherwise legally responsible according to the terms and conditions of the agreement with DHH. The span of control also includes systems and telecommunications capabilities outsourced by the CCN.

Special Healthcare Needs Population- An individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care requirements.

Specialist/Specialty Services - A specialist/subspecialist is a health care professional who is not a primary care physician.

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Start-Up Date - The date CCN providers begin providing medical care to their Medicaid members. Also referred to as “go-live date”.

State - The state of Louisiana.

State Plan - Refers to the Louisiana Medicaid State Plan.

Stratification- The process of partitioning data into distinct or non-overlapping groups.

Subspecialist Services - See Specialty Services

Supplemental Security Income (SSI) - A federal program which provides a cash benefit to people who are aged, blind or disabled and who have little or no income or assets Louisiana is a “Section 1634” state and anyone determined eligibility for SSI is automatically eligible for Medicaid.

SURS Reporting - Surveillance and Utilization Review Subsystems is reporting as required in the subsection under Fraud, Abuse and Waste Prevention.

System Availability - Measured within the CCN’s information system span of control. A system is considered not available when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after depressing the “enter” or other function key.

Targeted Case Management - Case management for a targeted population of persons paid by state plan. The State Plan defines special needs as: Special Needs is defined as a documented, established medical condition, as determined by a licensed physician, that has a high probability of resulting in a developmental delay or that gives rise to a need for multiple medical, social, educational and other services. In the case of a hearing impairment, the determination of special needs must be made by a licensed audiologist or physician.

Tertiary Care - Highly specialized medical care, usually over an extended period of time than involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

Third Party Liability (TPL) - Any monetary amount due for all or part of the cost of medical health care from a responsible third party.

Timely - Existing or taking place within the designated period; within the time required by statute or rules and regulations, contract terms, or policy requirements.

Title IV-E - Section of the Social Security Act of 1935 as amended that encompasses medical assistance for foster children and adoption assistance.

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Title V - Section of the Social Security Act of 1935 as amended that encompasses maternal child health services.

Title X - Section of the Social Security Act of 1935 as amended that encompasses and governs family planning services.

Title XIX - Section of the Social Security Act of 1935, as amended, that encompasses and governs the Medicaid program.

Title XXI - Section of the Social Security Act of 1935, as amended, that encompasses and governs the Children’s Health Insurance Program (CHIP).

TTY/TTD - Telephone Typewriter and Telecommunication Device for the Deaf, which allows for interpreter capability for deaf callers.

Universal Rate - The PMPM rate initially paid to CCNs prior to the first risk adjustment, calculated using fee-for-service (FFS) data for the entire CCN population.

Urban Area - Refers to a geographic area that meets the definition of urban area at § 412.62(f)(1)(ii) which is a Metropolitan Statistical Area(MSA) as defined by the Executive Office of Management and Budget; A list of Louisiana parishes in Metropolitan Statistical Areas can be found at <http://www.doa.louisiana.gov/census/metroareas.htm>

Urgent Care - Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. (Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, suspected fracture; urgent care requires timely face-to-face medical attention within 24 hours of member notification of the existence of an urgent condition.

Utilization Management (UM) - Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.

Validation - The review of information, data, and procedures to determine the extent to which data is accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Voluntary Population - Refers to categories of individuals eligible for, and enrolled in Louisiana Medicaid who are not mandated to enroll in a CCN. By default they will be included in the CCN program, but they may choose to opt out or disenroll at any time.

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Waiver - Medicaid Section 1915(c) Home and Community Based Services (HCBS) programs which in Louisiana are New Opportunities Waiver (NOW), Children’s Choice, Adult Day Health Care (ADHC), Elderly Disabled and Adult (EDA), Supports Waiver, Residential Options Waiver (ROW), and any other 1915(c) waiver that may be implemented. Participants in waivers are excluded from enrolling in a CCN.

WIC - (**Women, Infants and Children**) Federal program administered by the Office of Public Health that provides nutritional counseling; nutritional education; breast-feeding promotion and nutritious foods to pregnant, postpartum and breast-feeding women and infants and children up to the age of five (5) who are determined to be at nutritional risk and who have a low to moderate income. An individual who is eligible for Medicaid is automatically income eligible for WIC benefits.

Will - Denotes a mandatory requirement.

Willful - Refers to conscious or intentional but not necessarily malicious act.

Appendix B: Louisiana State Plan Services

LOUISIANA STATE PLAN SERVICES					
Services	CMS Classification	Children Age 0 through Age 20	Pregnant*** Women	Adult Ages 21 & Older	Service Limits and/or Prior Authorization
Audiology Services	Mandatory	√	√	N/A	√
Early, Periodic Screening, Diagnostic and Treatment (EPSDT)	Mandatory	√	√	N/A	√
Family Planning	Mandatory	√	√	√	√
Federally Qualified Health Center	Mandatory	√	√	√	√
Home Health	Mandatory	√	√	√	√
Inpatient & Outpatient Hospital Services	Mandatory	√	√	√	√
Emergency Room Services	Mandatory	√	√	√	√
Lab & X-Ray	Mandatory	√	√	√	√
Medical and Surgical Dental Services	Mandatory	√	√	N/A	√
Nurse Midwife	Mandatory	√	√	√	√
Nursing Facility	Mandatory	√	√	√	√
Pediatric and Family Nurse Practitioner	Mandatory	√	√	√	√
Personal Care Services (EPSDT)	Mandatory	N/A	N/A	√	√
Physician Services	Mandatory	√	√	√	√
Pregnancy Related Services	Mandatory	√	√	√	√
Rural Health Clinic	Mandatory	√	√	√	√
Adult Denture	Optional	N/A	√	√	√
Adult Immunizations	Optional	√	√	√	√
Ambulatory Surgical Services	Optional	√	√	√	√
Behavioral / Mental Health (Non-EPSDT)	Optional	N/A	√	√	√
Chiropractic Services	Optional	√	N/A	N/A	√
Clinic Services*	Optional	√	√	√	√
Community Mental Health Services	Optional	√	√	√	√
Durable Medical Equipment - Appliances & Supplies	Optional	√	√	√	√
Emergency Dental Services	Optional	√	√	√	√
End Stage Renal Disease Services	Optional	√	√	√	√
Expanded Dental For Pregnant Women	Optional	N/A	√	N/A	√
Home Health Extended	Optional	√	N/A	N/A	√
Hospice	Optional	√	√	√	√
Inpatient Psychiatric Services for Children under 21 and Adults over 65	Optional	√	√	√	√
Laboratory and X-ray Services	Optional	√	√	√	√
Medical Transportation - Emergency	Optional	√	√	√	√
Medical Transportation - Non-Emergency	Optional	√	√	√	√
Optometrist (Non-EPSDT)	Optional	N/A	√	√	√
Organ Transplants	Optional	√	√	√	√
Orthodontia	Optional	√	N/A	N/A	√
Personal Care Services (LT-PCS)	Optional	N/A	√	N/A	√
Pharmacy	Optional	√	√	√	√

LOUISIANA STATE PLAN SERVICES					
Services	CMS Classification	Children Age 0 through Age 20	Pregnant*** Women	Adult Ages 21 & Older	Service Limits and/or Prior Authorization
Podiatry	Optional	√	√	√	√
Prosthetic & Orthotic Devices	Optional	√	√	√	√
Rehabilitative Services **	Optional	√	√	√	√
Targeted Case Management	Optional	√	√	√	√
Legend: √ = Covered Service / √ = Service has Limits and/or Requires Prior Authorization / Required N/A = Not Applicable					

*Including non-IEP Medicaid covered services provided in schools, and when such services are not funded through certified public expenditures.

** Excludes specified early steps services.

***Shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes but is not limited to prenatal care, delivery, postpartum care, and family planning service for pregnant women in accordance with 42 CFR Part 440 Subpart B

Appendix C: Performance Measures

Louisiana Performance Measurement Set for Adult/Pediatric Networks

Access and Availability of Care	Effectiveness of Care		Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
<p>\$\$ Adults' Access to Preventive/ Ambulatory Health Services</p> <p>** HEDIS</p>	<p>Childhood Immunization Status</p> <p>**HEDIS/CHIPRA</p>	<p>\$\$ Chlamydia Screening in Women</p> <p>**HEDIS/CHIPRA</p>	<p>Well-Child Visits in the First 15 Months of Life</p> <p>**HEDIS/CHIPRA</p>	<p>Adult Asthma Admission Rate</p> <p>**AHRQ</p>	<p>CAHPS Health Plan Survey 4.0, Adult Version</p> <p>**HEDIS</p>
<p>Children and Adolescents Access to PCP</p> <p>** HEDIS/CHIPRA</p>	<p>Immunizations for Adolescents</p> <p>**HEDIS/CHIPRA</p>	<p>\$\$ Percent of live births weighing less than 2,500 grams</p> <p>**CHIPRA</p>	<p>\$\$ Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life</p> <p>**HEDIS/CHIPRA</p>	<p>CHF Admission Rate</p> <p>**AHRQ</p>	<p>\$\$ CAHPS Health Plan Survey 4.0, Child Version including Children With Chronic Conditions</p> <p>**HEDIS/CHIPRA</p>
<p>Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)</p> <p>**HEDIS/CHIPRA</p>	<p>\$\$ Lead screening in children</p> <p>**HEDIS</p>	<p>Cesarean Rate for Low-Risk First Birth Women</p> <p>**CHIPRA</p>	<p>\$\$ Adolescent Well-Care Visits</p> <p>**HEDIS/CHIPRA</p>	<p>Uncontrolled Diabetes Admission Rate</p> <p>**AHRQ</p>	<p>Provider Satisfaction</p> <p>**State</p>
	<p>Cervical CA Screening</p> <p>**HEDIS</p>	<p>Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents</p> <p>**HEDIS/CHIPRA</p>	<p>Adult Well-Care Visits</p> <p>**State</p>	<p>\$\$ Inpatient Hospital Readmission Rate within 30 Days</p> <p>**State</p>	
	<p>Breast CA Screening</p> <p>**HEDIS/CHIPRA</p>	<p>Appropriate Testing for Children With Pharyngitis</p> <p>**HEDIS/CHIPRA</p>	<p>\$\$ Ambulatory Care (ER Utilization)</p> <p>**HEDIS</p>		
	<p>Controlling High Blood Pressure</p> <p>**HEDIS</p>	<p>Use of Medication for people with Asthma</p> <p>**HEDIS/CHIPRA</p>	<p>Emergency Utilization-Avg # of ED visits per member per reporting period</p> <p>**CHIPRA</p>		
	<p>Follow-Up Care for Children Prescribed ADHD Medication</p> <p>**HEDIS/CHIPRA</p>	<p>\$\$ Comprehensive Diabetes Care</p> <p>**HEDIS</p>	<p>Annual # of asthma patients (1yr old) with 1 asthma related ER visit</p> <p>**CHIPRA</p>		
	<p>Otis Media Effusion</p> <p>**CHIPRA</p>	<p>HgbA1C testing in all children and adolescents diagnosed with diabetes</p> <p>**CHIPRA</p>	<p>Frequency of Ongoing Prenatal care</p> <p>**HEDIS/CHIPRA</p>		
	<p>ABCD Initiative Measures</p> <p>**CHIPRA</p>	<p>Total number of eligible women who receive 17-OH progesterone during pregnancy, and percent of preterm births at fewer than 37 weeks and fewer than 32 weeks in those recipients.</p> <p>** State</p>			
		<p>% of Pregnant women who are screened for tobacco usage and secondhand smoke exposure and is offered an appropriate and individualized intervention.</p> <p>** State</p>			

** Type of measure \$\$ Measures associated with incentives/disincentives

Louisiana Performance Measurement Set for Adult Networks

** Type of measure \$\$ Measures associated with incentives/disincentives

Access and Availability of Care	Effectiveness of Care	Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
\$\$Adults' Access to Preventive/ Ambulatory Health Services ** HEDIS	Breast CA Screening **HEDIS/CHIPRA	\$\$ Chlamydia Screening in Women **HEDIS/CHIPRA	Adult Well-Care Visits **State	\$\$ Adult Asthma Admission Rate **AHRQ \$\$ CAHPS Health Plan Survey 4.0, Adult Version **HEDIS
Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care) **HEDIS/CHIPRA	Cervical CA Screening **HEDIS	\$\$ Percent of live births weighing less than 2,500 grams **CHIPRA	\$\$ Ambulatory Care (ER Utilization) **HEDIS	\$\$ CHF Admission Rate **AHRQ Provider Satisfaction **State
	\$\$ Comprehensive Diabetes Care **HEDIS	Cesarean Rate for Low-Risk First Birth Women **CHIPRA	Frequency of Ongoing Prenatal Care **HEDIS/CHIPRA	\$\$ Uncontrolled Diabetes Admission Rate **AHRQ
	Controlling High Blood Pressure **HEDIS	Use of Medication for people with Asthma **HEDIS/CHIPRA		\$\$ Inpatient Hospital Readmission Rate within 30 Days **State
	Total number of eligible women who receive 17-OH progesterone during pregnancy, and percent of preterm births at fewer than 37 weeks and fewer than 32 weeks in those recipients. ** State	% of Pregnant women who are screened for tobacco usage and secondhand smoke exposure and is offered an appropriate and individualized intervention. ** State		

Louisiana Performance Measurement Set for Pediatric Networks

** Type of measure \$\$ Measures associated with incentives/disincentives

Access and Availability of Care	Effectiveness of Care		Use of Services	Prevention Quality Indicators	Satisfaction and Outcomes
\$\$Children and Adolescents Access to PCP ** HEDIS/CHIPRA	Childhood Immunization Status **HEDIS/CHIPRA	\$\$ Chlamydia Screening in Women **HEDIS/CHIPRA	Well-Child Visits in the First 15 Months of Life **HEDIS/CHIPRA	\$\$Inpatient Hospital Readmission Rate within 30 Days **State	\$\$ CAHPS Health Plan Survey 4.0, Child Version including Children With Chronic Conditions **HEDIS/CHIPRA
	\$\$ Immunizations for Adolescents **HEDIS/CHIPRA	\$\$ Lead screening in children **HEDIS	\$\$ Well-Child Visits in the Third, Fourth, Fifth and Sixth of Life **HEDIS/CHIPRA		Provider Satisfaction **State
	Follow-Up Care for Children Prescribed ADHD Medication **HEDIS/CHIPRA	\$\$ Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents **HEDIS/CHIPRA	\$\$ Adolescent Well-Care Visits **HEDIS/CHIPRA		
	ABCD Initiative Measures **CHIPRA	Appropriate Testing for Children With Pharyngitis **HEDIS/CHIPRA	\$\$ Ambulatory Care (ER Utilization) **HEDIS		
	HgbA1C testing in all children and adolescents diagnosed with diabetes **CHIPRA	Use of Medication for people with Asthma **HEDIS/CHIPRA	Emergency Utilization-Avg # of ED visits per member per reporting period **CHIPRA		
	Otis Media Effusion **CHIPRA		Annual # of asthma patients (1yr old) with 1 asthma related ER visit **CHIPRA		

Louisiana Administrative Performance Measurement Set

Measure	Minimal Performance Standard
Call Abandonment Rate	≥ 95%
Average Speed of Answer	30 seconds
Percentage of Calls answered within 30 seconds	≥90%
Total Complaints Resolved with 30 days	≥99%
Claims paid within 30 days	100%
Rejected claims returned to provider with reason code within 15 days of receipt of claims submission	≥99%
Claims Paid Financial Accuracy	≥99%
Claims Paid Processing Accuracy	≥97%

**Appendix D: Performance Improvement
Projects**

Provider Agreement for Coordinated Care Networks – Shared Savings

Performance Improvement Projects (PIPs)		
Section 1	Minimum Threshold	Specifications
Ambulatory Care Measure – ED Visit category - The number of ED visits per 1000 member months	2011 Medicaid NCQA Quality Compass at or below the 50 th Percentile	HEDIS
Section 2	Minimum Threshold	Specifications
Cervical CA Screening - The percentage of women 24-64 years old in the denominator that received a cervical CA screening	2011 Medicaid NCQA Quality Compass at or above the 50 th Percentile	HEDIS
Breast CA Screening - The percentage of women 40-69 years old that received a breast CA screening	2011 Medicaid NCQA Quality Compass at or above the 50 th Percentile	HEDIS
Well Child Visits in the First 15 Mths of Life - The percentage of children in the denominator that received at least 6 well child visits in the first 15 mths of life	2011 Medicaid NCQA Quality Compass at our above the 50 th Percentile	HEDIS
Childhood Immunization Status (CIS) The percentage of children two years of age who had the appropriate immunizations by their second birthday (Combination 2)	2011 Medicaid NCQA Quality Compass at our above the 50 th Percentile	HEDIS

**Appendix E: HIPAA Business Associate
Appendix**

HIPAA BUSINESS ASSOCIATE APPENDIX

A. Purpose

The Louisiana Department of Health and Hospitals (Covered Entity) and CCN (Business Associate) agree to the terms of this Appendix for the purpose of protecting the privacy of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191 (“HIPAA”), and regulations promulgated there under by the U.S. Department of Health and Human Services (the “HIPAA Regulations”); and Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), also known as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009, Public Law No. 111-005 (“ARRA”) in performing the functions, activities, or services for, or on behalf of, Covered Entity as specified in the Provider Agreement between the parties.

B. Definitions (Other terms used but not defined shall have the same meaning as those terms in the HIPAA Privacy Rule.)

1. Business Associate means the same as “business associate” in 45 CFR § 160.103.
2. Covered Entity means DHH.
3. Designated Record Set means the same as “designated record set” in 45 CFR § 164.501.
4. Individual means the same as "individual" in 45 CFR § 160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
5. Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 160 and Part 164, Subparts A and E).
6. Protected Health Information (PHI) means the same as the term protected health information in 45 CFR § 160.103, limited to information received by

Agency from Covered Entity.

7. Required By Law means the same as "required by law" in 45 CFR § 164.103, and other law applicable to the PHI disclosed pursuant to the Provider Agreement.
8. Secretary means the Secretary of the Department of Health and Hospitals or designee.
9. Security Standards shall mean the Security Standards at 45 C.F.R. Part 160 and Part 164, as may be amended.
10. Electronic PHI shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.
11. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system or its current meaning under 45 C.F.R. § 164.304.

C. Business Associate Provisions

Business Associate agrees to:

1. Not use or disclose PHI other than as permitted or required by the Provider Agreement or as required by law.
2. Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in the Provider Agreement.
3. Mitigate to the extent practicable, any harmful effect known to Business Associate if it uses/discloses PHI in violation of the Provider Agreement.
4. Notify Covered Entity of any actual or suspected breaches in privacy or security that compromise PHI. Notification of security and/or privacy breaches should be given to:

Louisiana Department of Health and Hospitals

Bureau of Legal Services
Post Office Box 3836
Baton Rouge, Louisiana 70821
Phone: (225) 342-1112
Fax: (225) 342-2232

Business Associate shall give initial notification immediately upon its discovery of a breach, but in no event later than one (1) business day after discovery. The initial notification shall include all relevant information which is known and available to Business Associate at that time.

Business Associate shall provide a detailed description of the breach to Covered Entity within five (5) business days after discovery, except when despite all reasonable efforts by Business Associate to obtain the information required, circumstances beyond its control necessitate additional time. Under such circumstances, Business Associate shall provide the detailed description to Covered Entity as soon as possible and without unreasonable delay, but in no event later than fifteen (15) business days after the discovery of a breach. The detailed description shall include, at a minimum:

- a. The date of the breach;
- b. The date of the discovery of the breach;
- c. A description of the types of PHI that were involved;
- d. Identification of each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed;
- e. Any measures that have been taken by the Business Associate to mitigate the breach; and
- f. Any other details necessary to complete an assessment of the risk of harm to the individuals affected by the breach.

If Business Associate fails to give initial notification of a breach to DHH within one (1) business day after it discovered or should have discovered

the breach, DHH may impose liquidated damages of \$300 per day from the date that the Business Associate should have given initial notification to the date that DHH becomes aware of the breach.

DHH may impose monetary penalties of up to \$25,000 for any breach in privacy or security that compromises PHI.

5. Ensure that any agent/contractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Appendix.
6. If the Business Associate has PHI in a designated record set: (1) provide access at Covered Entity's request to PHI to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR § 164.524; (2) make any amendment(s) to PHI in a designated record set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526.
7. Make its internal practices, books, records, and policies/procedures relating to the use/disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity, to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
8. Document Business Associate disclosures of PHI, other than disclosures back to Covered Entity, and related information as would be required for Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.
9. Provide to Covered Entity or an individual, as designated by Covered Entity, information collected in accordance with Section C.8 of this Appendix, to permit Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.
10. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs,

DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPods, and MP3 and MP4 players), and personal organizers.

11. Otherwise, not re-disclose Covered Entity PHI except as permitted by applicable law.
12. Be liable to Covered Entity for any damages, penalties and/or fines assessed against Covered Entity should Covered Entity be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this section. Covered Entity is authorized to recoup any and all such damages, penalties and/or fines assessed against Covered Entity by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which Covered Entity may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and Covered Entity, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in the Provider Agreement, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Provider Agreement, provided that such use would not violate the Privacy Rule if done by Covered Entity or Covered Entity's privacy practices. Unless otherwise permitted in this Appendix, in the Provider Agreement or required by law, Business Associate may not disclose/re-disclose PHI except to Covered Entity.
2. Except as limited in this Appendix, Business Associate may use/disclose PHI for internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide its services under the Provider Agreement.
3. Except as limited in this Appendix, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

4. Business Associate may use PHI to report violations to appropriate Federal or State authorities as permitted by § 164.502(j)(1).

E. Covered Entity Provisions

Covered Entity agrees to:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
2. Notify Business Associate of any changes in, or revocation of, permission by individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.
4. Not request Business Associate to use/disclose PHI in any manner not permitted under the Privacy Rule if done by Covered Entity.

F. Term and Termination

1. The terms of this Appendix shall be effective immediately upon signing of both the Provider Agreement and this Appendix, and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.
2. Upon its knowledge of a material breach by Business Associate, Covered Entity shall either:

- a. Allow Business Associate to cure the breach or end the violation and terminate the Provider Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
- b. Immediately terminate the Provider Agreement if Business Associate has breached a material term of this Appendix and cure is not possible; or
- c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

3. Effect of Termination

- a. Except as provided in paragraph (b) below, upon termination of the Provider Agreement, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision also applies to PHI in the possession of Business Associate's contractors or agents. Business Associate shall retain no copies of the PHI.
- b. If Business Associate determines that returning the PHI is infeasible, Business Associate shall notify Covered Entity of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Appendix to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, and will require that its agents and contractors to whom it provides such information do the same. Further, Business Associate agrees to comply with Covered Entity's security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate's

Provider Agreement for Coordinated Care Networks – Shared Savings

security and confidentiality policies, processes, and practices that affect electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate’s security and confidentiality practices, policies, and processes comply with HIPAA and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

H. Miscellaneous

1. A reference in this Appendix to a section in the Privacy Rule means the section as in effect or as amended.
2. The Parties agree to amend this Appendix as necessary to comply with HIPAA and other applicable law.
3. The respective rights and obligations of Business Associate under § F. 3 shall survive the termination of the Provider Agreement.
4. Any ambiguity in this Appendix shall be resolved to permit Covered Entity to comply with the Privacy Rule.

CCN Provider Representative

Title: _____

Please print Name: _____

Date: _____

DHH Representative

Title: _____

Please print Name: _____

Date: _____

**Appendix F: Schedule of Enhanced Primary
Care Case Management Fee Rates**

Enhanced Primary Care Case Management Fee Rates

Effective January 1, 2011 – December 31, 2014

Level 1:

Families and Children.....14.81

Level 2:

SSI21.16

Pregnant Women.....21.16

Foster Care21.16

SSI = Supplemental Security Income

Appendix G: Enhanced Primary Care Case Management Fee Crosswalk

Appendix E

Coordinated Care Network - Shared Savings Model - Enhanced Care Management Fee Crosswalk

Eligibility Type Case	Type Case Description	Eligibility Aid Category	Category of Assistance (COA) Description	Crosswalk Code Description	Level 1 Reimbursement	Level 2 Reimbursement
&□0	Unknown	UN	Unknown	Excluded COA		
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	01	Aged	SSI		X
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	02	Blind	SSI		X
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	03	Families and Children	Family and Children	X	
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	04	Disabled	SSI		X
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	05	Refugee Asst	Excluded COA		
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	11	Hurricane Evacuees	Excluded COA		
001	SSI Conversion / Refugee Cash Assistance (RCA) / LIFC Basic	13	LIFC	Family and Children	X	
002	Deemed Eligible	03	Families and Children	Family and Children	X	
002	Deemed Eligible	11	Hurricane Evacuees	Excluded COA		
003	SSI Conversion	01	Aged	SSI		X
003	SSI Conversion	02	Blind	SSI		X
003	SSI Conversion	04	Disabled	SSI		X
005	SSI/LTC	01	Aged	Excluded COA		
005	SSI/LTC	02	Blind	Excluded COA		
005	SSI/LTC	04	Disabled	Excluded COA		
005	SSI/LTC	06	OCS Foster Care	Excluded COA		
005	SSI/LTC	08	IV-E OCS/OYD	Excluded COA		
005	SSI/LTC	11	Hurricane Evacuees	Excluded COA		
007	LACHIP Phase 1	03	Families and Children	LaChip	X	
007	LACHIP Phase 1	06	OCS Foster Care	Foster Care Children		X
007	LACHIP Phase 1	11	Hurricane Evacuees	Excluded COA		
007	LACHIP Phase 1	22	OCS/OYD (XIX)	Foster Care Children		X
008	PAP - Prohibited AFDC Provisions	03	Families and Children	Family and Children	X	
008	PAP - Prohibited AFDC Provisions	11	Hurricane Evacuees	Excluded COA		
009	LIFC - Unemployed Parent / CHAMP	11	Hurricane Evacuees	Excluded COA		
009	LIFC - Unemployed Parent / CHAMP	13	LIFC	Family and Children	X	
012	Presumptive Eligibility, Pregnant Woman	16	Presumptive Eligible	Excluded COA		
013	CHAMP Pregnant Woman (to 133% of FPIG)	03	Families and Children	Pregnant Women		X
013	CHAMP Pregnant Woman (to 133% of FPIG)	06	OCS Foster Care	Pregnant Women		X
013	CHAMP Pregnant Woman (to 133% of FPIG)	11	Hurricane Evacuees	Excluded COA		
013	CHAMP Pregnant Woman (to 133% of FPIG)	22	OCS/OYD (XIX)	Foster Care Children		X
014	CHAMP Child	03	Families and Children	Family and Children	X	
014	CHAMP Child	06	OCS Foster Care	Foster Care Children		X
014	CHAMP Child	11	Hurricane Evacuees	Excluded COA		
014	CHAMP Child	22	OCS/OYD (XIX)	Foster Care Children		X
015	LACHIP Phase 2	03	Families and Children	LaChip	X	
015	LACHIP Phase 2	11	Hurricane Evacuees	Excluded COA		
018	ADHC (Adult Day Health Services Waiver)	01	Aged	Excluded		
018	ADHC (Adult Day Health Services Waiver)	02	Blind	Excluded		
018	ADHC (Adult Day Health Services Waiver)	04	Disabled	Excluded		
019	SSI/ADHC	01	Aged	Excluded		
019	SSI/ADHC	02	Blind	Excluded		

Appendix E

Coordinated Care Network - Shared Savings Model - Enhanced Care Management Fee Crosswalk

Eligibility Type Case	Type Case Description	Eligibility Aid Category	Category of Assistance (COA) Description	Crosswalk Code Description	Level 1 Reimbursement	Level 2 Reimbursement
019	SSI/ADHC	04	Disabled	Excluded		
020	Regular MNP (Medically Needy Program)	03	Families and Children	Family and Children	X	
020	Regular MNP (Medically Needy Program)	11	Hurricane Evacuees	Excluded COA		
020	Regular MNP (Medically Needy Program)	14	Med Asst/Appeal	Excluded COA		
021	Spend-Down MNP	01	Aged	Excluded COA		
021	Spend-Down MNP	02	Blind	Excluded COA		
021	Spend-Down MNP	03	Families and Children	Excluded COA		
021	Spend-Down MNP	04	Disabled	Excluded COA		
021	Spend-Down MNP	11	Hurricane Evacuees	Excluded COA		
022	LTC Spend-Down MNP (Income > Facility Fee)	01	Aged	Excluded COA		
022	LTC Spend-Down MNP (Income > Facility Fee)	04	Disabled	Excluded COA		
023	SSI Transfer of Resource(s)/LTC	01	Aged	Excluded COA		
023	SSI Transfer of Resource(s)/LTC	04	Disabled	Excluded COA		
024	Transfer of Resource(s)/LTC	01	Aged	Excluded COA		
024	Transfer of Resource(s)/LTC	04	Disabled	Excluded COA		
025	LTC Spend-Down MNP	01	Aged	Excluded COA		
025	LTC Spend-Down MNP	04	Disabled	Excluded COA		
025	LTC Spend-Down MNP	11	Hurricane Evacuees	Excluded COA		
026	SSI/EDA Waiver	01	Aged	Excluded COA		
026	SSI/EDA Waiver	02	Blind	Excluded COA		
026	SSI/EDA Waiver	04	Disabled	Excluded COA		
027	EDA Waiver	01	Aged	Excluded COA		
027	EDA Waiver	02	Blind	Excluded COA		
027	EDA Waiver	04	Disabled	Excluded COA		
027	EDA Waiver	11	Hurricane Evacuees	Excluded COA		
028	Tuberculosis (TB)	20	TB	Excluded COA		
029	Foster Care IV-E - Suspended SSI	08	IV-E OCS/OYD	Foster Care Children		X
030	Regular Foster Care Child	06	OCS Foster Care	Foster Care Children		X
031	IV-E Foster Care	08	IV-E OCS/OYD	Foster Care Children		X
032	YAP (Young Adult Program)	22	OCS/OYD (XIX)	Foster Care Children		X
033	OYD - V Category Child	22	OCS/OYD (XIX)	Foster Care Children		X
035	YAP/OYD	22	OCS/OYD (XIX)	Foster Care Children		X
036	YAP (Young Adult Program)	15	OCS/OYD Child	Excluded COA		
037	OYD (Office of Youth Development)	15	OCS/OYD Child	Excluded COA		
038	OCS Child Under Age 18 (State Funded)	15	OCS/OYD Child	Excluded COA		
039	State Retirees	14	Med Asst/Appeal	Excluded COA		
040	SLMB (Specified Low-Income Medicare Beneficiary)	01	Aged	Excluded COA		
040	SLMB (Specified Low-Income Medicare Beneficiary)	02	Blind	Excluded COA		
040	SLMB (Specified Low-Income Medicare Beneficiary)	04	Disabled	Excluded COA		
043	New Opportunities Waiver - SSI	01	Aged	Excluded COA		
043	New Opportunities Waiver - SSI	02	Blind	Excluded COA		
043	New Opportunities Waiver - SSI	04	Disabled	Excluded COA		
043	New Opportunities Waiver - SSI	06	OCS Foster Care	Excluded COA		
043	New Opportunities Waiver - SSI	08	IV-E OCS/OYD	Excluded COA		

Appendix E

Coordinated Care Network - Shared Savings Model - Enhanced Care Management Fee Crosswalk

Eligibility Type Case	Type Case Description	Eligibility Aid Category	Category of Assistance (COA) Description	Crosswalk Code Description	Level 1 Reimbursement	Level 2 Reimbursement
043	New Opportunities Waiver - SSI	22	OCS/OYD (XIX)	Excluded COA		
045	SSI PCA Waiver	01	Aged	Excluded COA		
045	SSI PCA Waiver	02	Blind	Excluded COA		
045	SSI PCA Waiver	04	Disabled	Excluded COA		
046	PCA Waiver	01	Aged	Excluded COA		
046	PCA Waiver	02	Blind	Excluded COA		
046	PCA Waiver	04	Disabled	Excluded COA		
046	PCA Waiver	14	Med Asst/Appeal	Excluded COA		
047	Illegal/Ineligible Aliens Emergency Services	01	Aged	Excluded COA		
047	Illegal/Ineligible Aliens Emergency Services	03	Families and Children	Excluded COA		
047	Illegal/Ineligible Aliens Emergency Services	04	Disabled	Excluded COA		
047	Illegal/Ineligible Aliens Emergency Services	11	Hurricane Evacuees	Excluded COA		
048	QI-1 (Qualified Individual - 1)	01	Aged	Excluded COA		
048	QI-1 (Qualified Individual - 1)	02	Blind	Excluded COA		
048	QI-1 (Qualified Individual - 1)	04	Disabled	Excluded COA		
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	01	Aged	Excluded COA		
049	QI-2 (Qualified Individual - 2) (Program terminated 12/31/2002)	04	Disabled	Excluded COA		
050	PICKLE	01	Aged	SSI		X
050	PICKLE	02	Blind	SSI		X
050	PICKLE	04	Disabled	SSI		X
050	PICKLE	11	Hurricane Evacuees	Excluded COA		
051	LTC MNP/Transfer of Resources	01	Aged	Excluded COA		
051	LTC MNP/Transfer of Resources	04	Disabled	Excluded COA		
052	Breast and/or Cervical Cancer	03	Families and Children	SSI		X
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	03	Families and Children	Pregnant Women		X
053	CHAMP Pregnant Woman Expansion (to 185% FPIG)	11	Hurricane Evacuees	Excluded COA		
055	LACHIP Phase 3	03	Families and Children	LaChip		X
055	LACHIP Phase 3	11	Hurricane Evacuees	Excluded COA		
056	Disabled Widow/Widower (DW/W)	01	Aged	SSI		X
056	Disabled Widow/Widower (DW/W)	04	Disabled	SSI		X
057	BPL (Walker vs. Bayer)	04	Disabled	SSI		X
058	Section 4913 Children	04	Disabled	SSI		X
059	Disabled Adult Child	01	Aged	SSI		X
059	Disabled Adult Child	02	Blind	SSI		X
059	Disabled Adult Child	04	Disabled	SSI		X
059	Disabled Adult Child	11	Hurricane Evacuees	Excluded COA		
060	Early Widow/Widowers	02	Blind	SSI		X
060	Early Widow/Widowers	04	Disabled	SSI		X
061	SGA Disabled W/W/DS	02	Blind	SSI		X
061	SGA Disabled W/W/DS	04	Disabled	SSI		X
062	SSI/Public ICF/DD	01	Aged	Excluded COA		
062	SSI/Public ICF/DD	02	Blind	Excluded COA		
062	SSI/Public ICF/DD	04	Disabled	Excluded COA		
062	SSI/Public ICF/DD	06	OCS Foster Care	Excluded COA		

Appendix E

Coordinated Care Network - Shared Savings Model - Enhanced Care Management Fee Crosswalk

Eligibility Type Case	Type Case Description	Eligibility Aid Category	Category of Assistance (COA) Description	Crosswalk Code Description	Level 1 Reimbursement	Level 2 Reimbursement
062	SSI/Public ICF/DD	08	IV-E OCS/OYD	Excluded COA		
062	SSI/Public ICF/DD	22	OCS/OYD (XIX)	Excluded COA		
063	LTC Co-Insurance	01	Aged	Excluded COA		
063	LTC Co-Insurance	02	Blind	Excluded COA		
063	LTC Co-Insurance	04	Disabled	Excluded COA		
063	LTC Co-Insurance	11	Hurricane Evacuees	Excluded COA		
064	SSI/Private ICF/DD	01	Aged	Excluded COA		
064	SSI/Private ICF/DD	02	Blind	Excluded COA		
064	SSI/Private ICF/DD	04	Disabled	Excluded COA		
064	SSI/Private ICF/DD	06	OCS Foster Care	Excluded COA		
064	SSI/Private ICF/DD	08	IV-E OCS/OYD	Excluded COA		
064	SSI/Private ICF/DD	22	OCS/OYD (XIX)	Excluded COA		
065	Private ICF/DD	01	Aged	Excluded COA		
065	Private ICF/DD	02	Blind	Excluded COA		
065	Private ICF/DD	04	Disabled	Excluded COA		
065	Private ICF/DD	06	OCS Foster Care	Excluded COA		
065	Private ICF/DD	08	IV-E OCS/OYD	Excluded COA		
065	Private ICF/DD	22	OCS/OYD (XIX)	Excluded COA		
070	New Opportunities Waiver, non-SSI	01	Aged	Excluded COA		
070	New Opportunities Waiver, non-SSI	02	Blind	Excluded COA		
070	New Opportunities Waiver, non-SSI	04	Disabled	Excluded COA		
070	New Opportunities Waiver, non-SSI	06	OCS Foster Care	Excluded COA		
070	New Opportunities Waiver, non-SSI	08	IV-E OCS/OYD	Excluded COA		
070	New Opportunities Waiver, non-SSI	22	OCS/OYD (XIX)	Excluded COA		
071	Transitional Medicaid	03	Families and Children	Family and Children	X	
071	Transitional Medicaid	13	LIFC	Family and Children	X	
076	SSI Children's Waiver - Louisiana Children's Choice	02	Blind	Excluded COA		
076	SSI Children's Waiver - Louisiana Children's Choice	04	Disabled	Excluded COA		
076	SSI Children's Waiver - Louisiana Children's Choice	06	OCS Foster Care	Excluded COA		
076	SSI Children's Waiver - Louisiana Children's Choice	08	IV-E OCS/OYD	Excluded COA		
076	SSI Children's Waiver - Louisiana Children's Choice	22	OCS/OYD (XIX)	Excluded COA		
077	Children's Waiver - Louisiana Children's Choice	04	Disabled	Excluded COA		
077	Children's Waiver - Louisiana Children's Choice	06	OCS Foster Care	Excluded COA		
077	Children's Waiver - Louisiana Children's Choice	08	IV-E OCS/OYD	Excluded COA		
077	Children's Waiver - Louisiana Children's Choice	22	OCS/OYD (XIX)	Excluded COA		
078	SSI (Supplemental Security Income)	01	Aged	SSI		X
078	SSI (Supplemental Security Income)	02	Blind	SSI		X
078	SSI (Supplemental Security Income)	04	Disabled	SSI		X
078	SSI (Supplemental Security Income)	06	OCS Foster Care	Foster Care Children		X
078	SSI (Supplemental Security Income)	08	IV-E OCS/OYD	Foster Care Children		X
078	SSI (Supplemental Security Income)	22	OCS/OYD (XIX)	Foster Care Children		X
079	Denied SSI Prior Period	01	Aged	Excluded COA		
079	Denied SSI Prior Period	04	Disabled	Excluded COA		
080	Terminated SSI Prior Period	01	Aged	Excluded COA		

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Coordinated Care Network - Shared Savings Model - Enhanced Care Management Fee Crosswalk

Eligibility Type Case	Type Case Description	Eligibility Aid Category	Category of Assistance (COA) Description	Crosswalk Code Description	Level 1 Reimbursement	Level 2 Reimbursement
080	Terminated SSI Prior Period	04	Disabled	Excluded COA		
081	Former SSI	01	Aged	SSI		X
081	Former SSI	02	Blind	SSI		X
081	Former SSI	04	Disabled	SSI		X
082	SSI DD Waiver	01	Aged	Excluded COA		
082	SSI DD Waiver	02	Blind	Excluded COA		
082	SSI DD Waiver	04	Disabled	Excluded COA		
082	SSI DD Waiver	06	OCS Foster Care	Excluded COA		
082	SSI DD Waiver	08	IV-E OCS/OYD	Excluded COA		
082	SSI DD Waiver	22	OCS/OYD (XIX)	Excluded COA		
083	Acute Care Hospitals (LOS > 30 days)	01	Aged	SSI		X
083	Acute Care Hospitals (LOS > 30 days)	04	Disabled	SSI		X
083	Acute Care Hospitals (LOS > 30 days)	11	Hurricane Evacuees	Excluded COA		
085	Grant Review	03	Families and Children	Family and Children	X	
085	Grant Review	13	LIFC	Family and Children	X	
086	Forced Benefits	01	Aged	Excluded COA		
086	Forced Benefits	03	Families and Children	Excluded COA		
086	Forced Benefits	04	Disabled	Excluded COA		
086	Forced Benefits	05	Refugee Asst	Excluded COA		
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	02	Blind	SSI		X
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	04	Disabled	SSI		X
088	Medicaid Buy-In Working Disabled (Medicaid Purchase Plan)	11	Hurricane Evacuees	Excluded COA		
090	LTC (Long Term Care)	01	Aged	Excluded COA		
090	LTC (Long Term Care)	02	Blind	Excluded COA		
090	LTC (Long Term Care)	03	Families and Children	Excluded COA		
090	LTC (Long Term Care)	04	Disabled	Excluded COA		
090	LTC (Long Term Care)	08	IV-E OCS/OYD	Excluded COA		
090	LTC (Long Term Care)	11	Hurricane Evacuees	Excluded COA		
090	LTC (Long Term Care)	14	Med Asst/Appeal	Excluded COA		
093	DD Waiver	01	Aged	Excluded COA		
093	DD Waiver	02	Blind	Excluded COA		
093	DD Waiver	04	Disabled	Excluded COA		
093	DD Waiver	06	OCS Foster Care	Excluded COA		
093	DD Waiver	08	IV-E OCS/OYD	Excluded COA		
093	DD Waiver	22	OCS/OYD (XIX)	Excluded COA		
095	QMB (Qualified Medicare Beneficiary)	17	QMB	Excluded COA		
099	Public ICF/DD	01	Aged	Excluded COA		
099	Public ICF/DD	02	Blind	Excluded COA		
099	Public ICF/DD	04	Disabled	Excluded COA		
099	Public ICF/DD	06	OCS Foster Care	Excluded COA		
099	Public ICF/DD	08	IV-E OCS/OYD	Excluded COA		
100	PACE SSI	01	Aged	Excluded COA		
100	PACE SSI	04	Disabled	Excluded COA		
101	PACE SSI-related	01	Aged	Excluded COA		

Appendix E

Coordinated Care Network - Shared Savings Model - Enhanced Care Management Fee Crosswalk

Eligibility Type Case	Type Case Description	Eligibility Aid Category	Category of Assistance (COA) Description	Crosswalk Code Description	Level 1 Reimbursement	Level 2 Reimbursement
101	PACE SSI-related	04	Disabled	Excluded COA		
104	Pregnant women with income greater than 118% of FPL and less than	03	Families and Children	Pregnant Women		X
104	Pregnant women with income greater than 118% of FPL and less than	11	Hurricane Evacuees	Excluded COA		
115	Family Planning, Previous LAMOMS eligibility	40	Family Planning	Excluded COA		
116	Family Planning, New eligibility / Non LaMOM	40	Family Planning	Excluded COA		
117	Supports Waiver SSI	01	Aged	Excluded COA		
117	Supports Waiver SSI	02	Blind	Excluded COA		
117	Supports Waiver SSI	04	Disabled	Excluded COA		
118	Supports Waiver	01	Aged	Excluded COA		
118	Supports Waiver	02	Blind	Excluded COA		
118	Supports Waiver	04	Disabled	Excluded COA		
125	Disability Medicaid	01	Aged	SSI		X
125	Disability Medicaid	04	Disabled	SSI		X
127	LaCHIP Phase IV: Non-Citizen Pregnant Women Expansion	03	Families and Children	Pregnant Women		X
130	LTC Payment Denial/Late Admission Packet	01	Aged	Excluded COA		
130	LTC Payment Denial/Late Admission Packet	04	Disabled	Excluded COA		
131	SSI Payment Denial/Late Admission	04	Disabled	Excluded COA		
132	Spenddown Denial of Payment/Late Packet	01	Aged	Excluded COA		
132	Spenddown Denial of Payment/Late Packet	04	Disabled	Excluded COA		
133	Family Opportunity Program	04	Disabled	SSI		X
134	LaCHIP Affordable Plan	03	Families and Children	Excluded COA		
136	Private ICF/DD Spenddown Medically Needy Program	04	Disabled	Excluded COA		
137	Public ICF/DD Spenddown Medically Needy Program	04	Disabled	Excluded COA		
138	Private ICF/DD Spenddown MNP/Income Over Facility Fee	04	Disabled	Excluded COA		
178	Disabled Adults authorized for special hurricane Katrina assistance	01	Aged	Excluded COA		
178	Disabled Adults authorized for special hurricane Katrina assistance	04	Disabled	Excluded COA		
178	Disabled Adults authorized for special hurricane Katrina assistance	11	Hurricane Evacuees	Excluded COA		
UN	Unknown	UN	Unknown	Excluded COA		
131	SSI Payment Denial/Late Admission	01	Aged	Excluded COA		
137	Public ICF/DD Spenddown Medically Needy Program	02	Blind	Excluded COA		
148	Youth Aging Out of Foster Care (Chaffee Option)	03	Families and Children	Foster Care Children		X
149	New Opportunities Waiver Fund	01	Aged	Excluded COA		
149	New Opportunities Waiver Fund	04	Disabled	Excluded COA		
149	New Opportunities Waiver Fund	08	IV-E OCS/OYD	Excluded COA		
150	SSI New Opportunities Waiver Fund	01	Aged	Excluded COA		
150	SSI New Opportunities Waiver Fund	04	Disabled	Excluded COA		

Appendix H
**Enhanced Primary Care Case Management Fee
Development Methodology**

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GUY CARPENTER OLIVER WYMAN

F. Ronald Ogborne III, FSA, CERA, MAAA

3131 East Camelback Road, Suite 300
Phoenix, AZ 85016
+1 602 522 6595 Fax +1 602 957 9573
www.mercer.com

Ms. Ruth Kennedy
Deputy Director of Medicaid and LaCHIP
Bienville Building
628 North 4th Street – 7th Floor
Baton Rouge, LA 70821

August 13, 2010

Subject: Enhanced Primary Care Case Management fee estimate methodology

Dear Ms. Kennedy:

In partnership with the State of Louisiana (State), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, developed best estimates of the total enhanced Primary Care Case Management (ePCCM) fees for the Coordinated Care Network – Shared Savings (CCN-S) program being developed by the State for the period of January 1, 2011 to December 31, 2011. This letter presents an overview of the analyses and methodology used to develop these total ePCCM fee estimates.

The total ePCCM fee that will be paid by the State to the CCN-S entities on a per-member-per-month (PMPM) basis consists of two components:

- A primary care provider (PCP) care management fee for care management services provided directly by a PCP for each member to whom they are linked
- An enhanced primary care management fee for all other services provided by the network under the Provider Agreement

The State has independently established \$3.00 as the PCP care management fee for all CCN-S participants based on historical experience from the CommunityCare program.

The enhanced primary care management fee component was developed by Mercer and is the primary focus of this letter. This fee component will be dependent upon the Medicaid eligibility category of each enrollee and will be subject, in aggregate, to a reconciliation of the savings achieved under the program.

All assumptions underlying the total ePCCM fee estimates presented in this document have been developed based on the specifications outlined in the June 7, 2010 draft of the CCN-S Provider Agreement. To the extent that significant changes are made to this agreement, these total ePCCM fee estimates may need to be adjusted accordingly.



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Program overview

The CCN-S model will function as a State Plan program whereby PCPs join with a CCN-S, the ePCCM entity, to create a formal and distinct network of PCPs to coordinate the full continuum of care while achieving budget and performance goals and benchmarks.

Through contractual arrangements with the State, the CCN-S entities and their PCPs will provide the State with the ability to ensure accountability while improving access, coordinating care and promoting healthier outcomes.

Eligibility

The following eligibility groups of Medicaid recipients are required to enroll in a CCN-S on a mandatory basis unless they meet any of the conditions for exclusion from participation:

- Temporary Assistance for Needy Families (TANF) and TANF-related recipients
- LaCHIP recipients
- Pregnant Women
- Breast and Cervical Cancer Program participants
- Aged, Blind and Disabled Individuals age 19 or older

The following groups of Medicaid recipients will be allowed to participate in a CCN on a voluntary basis, but will not be required to do so:

- Supplemental Security Income (SSI) or Disability Medicaid Program recipients under age 19
- Indians who are members of federally recognized tribes
- Children with special health care needs
- Children in foster care or other out-of-home placement or receiving adoption assistance

Medicaid recipients in either a mandatory or voluntary enrollment group who meet one or more of the following conditions are excluded from participation in a CCN:

- Individuals residing in a nursing facility or intermediate care facility for the developmentally disabled
- Individuals receiving hospice services
- Individuals with Medicare coverage
- Individuals who are receiving services through the Tuberculosis Infected Individuals Program
- Individuals receiving services through a 1915(c) waiver
- Individuals under the age of 21 who are listed on the New Opportunities Waiver Registry
- Individuals enrolled in the Program of All-Inclusive Care for the Elderly
- Individuals with a limited eligibility period including Spend-down Medically Needy Program and Emergency Services Only participants

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- Individuals enrolled in the LaCHIP Affordable Plan Program
- Individuals enrolled in the Take Charge Program

Covered services

The CCN-S entities must demonstrate the capacity to manage targeted populations through:

- Care Management
- Care Coordination
- Utilization Management and Prior Authorization
- Case Management
- Chronic Care Management
- Quality Management
- Customer Service

The CCN-S entities will also promote and facilitate the capacity of its PCP practices to meet the recognition requirements of a National Committee for Quality Assurance (NCQA) Physician Practice Connections® – Patient-Centered Medical Home and fulfill the reporting requirements and provider monitoring responsibilities as set forth in the Provider Agreement.

The enhanced primary care management fee component of the total ePCCM fee is payment-in-full for these services, with the exception of any payments associated with the savings reconciliation. Claims for medical treatment or diagnostic services will continue to be paid by the State on a fee-for-service basis.

Enhanced primary care management fee range development

Data sources

In support of the development of the enhanced primary care management fee estimates, Mercer relied upon the following data sources:

- PayMonitor® database of employee salaries by job type
- State enrollment projections for potential CCN-S entities

Additionally, Mercer relied upon their experience in working with PCCM, Disease Management and Medical Home Initiatives for other state Medicaid programs, as well as the expertise of Mercer clinicians familiar with the operation of similar programs in other populations.

Enrollment assumptions

In order to develop enhanced primary care management fee component estimates, it was necessary to make assumptions regarding the enrollment levels of prospective CCN-S entities. As specified in the Provider Agreement, each entity shall have the capacity to enroll a minimum of

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15,000 participants. Conversely, the State is not currently anticipating that any prospective CCN-S entities will exceed 30,000 participants during the calendar year (CY) 2011 contract period.

Based on the available information and experiences observed in similar programs, Mercer selected enrollment assumptions for this analysis that reflected a balance of the following factors:

- Expected CCN-S enrollment levels during the contract period
- Potential challenges associated with bringing a new program or entity to operational readiness
- Realistic expectations for the economies of scale and management efficiencies that a well-managed CCN-S should be able to achieve

Fee components

Based on the requirements outlined in the Provider Agreement, program costs were classified into the following seven components:

- Prior Authorization
- Patient Centered Medical Home
- Care Coordination
- Case Management and Chronic Care Management
- Customer Service
- Provider Monitoring and Services
- Quality Management, Compliance and Fraud Monitoring

Each component was further divided into fixed and variable costs and total costs were estimated using a staffing and salary requirements and/or annual budget approach. In some cases, both methods were applied to different elements within the same component.

Staffing and salary requirements approach

Under the staffing and salary requirements approach, Mercer relied on specified staffing requirements and clinical expertise in conjunction with enrollment assumptions to develop estimates of the number of full time employees a well-managed CCN-S entity would need to employ to fulfill their obligations under the Provider Agreement.

Once appropriate staffing levels were estimated, salary requirements for each type of employee were used to estimate the cost of a particular component or subcomponent. Average yearly cash compensation levels for each position type were estimated based on Mercer's PayMonitor® and include provisions for the cost of additional benefits, such as medical insurance and retirement benefits, to compute the total compensation.

The number of employees and the total annual compensation levels were combined to produce total projected cost estimates.



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Annual budget approach

Projected costs for a small subset of subcomponents were estimated using the annual budget approach. For these functions and duties, Mercer relied on its experience in working with similar programs and market research to develop annual budget estimates for the tasks required by the Provider Agreement.

Variation in fee components estimates by population

In accordance with the Provider Agreement, the State will pay distinct enhanced primary care case management fees for TANF/LaCHIP-related and SSI-related enrollees. As such, best estimates of the enhanced primary care management fee component have been developed for each population. For the Patient-Centered Medical Home; Care Coordination; Customer Service; Provider Monitoring and Services and Quality Management, Compliance and Fraud Monitoring tasks within the enhanced primary care management fee component, CCN-S entity costs are not expected to vary significantly based on the relative acuity of the population being served.

For the remaining components (i.e., Prior Authorization and Case Management and Chronic Care Management), however, staffing ratios for subcomponents related to specific functions, such as claims review, or that involve direct interaction with enrollees were adjusted to reflect differences in the prevalence of chronic diseases and the overall level healthcare needs between the two populations. The adjustments were developed based on a review of relevant literature, prevalence rates in similar populations in other states and the expertise of Mercer's clinicians.

All cost projections were reviewed for reasonableness both individually and in total by Mercer clinicians with experience in operating similar programs.

Account management and overhead

To provide ePCCM services, there are account management and overhead costs that each CCN-S entity must incur in addition to the components described above. These costs include, but are not limited to, facility costs, hardware and software costs, transportation costs, and the cost of capital.

Such costs are typically proportional to the total number of full time employees and/or the total operational cost of an entity. Provisions for account management and overhead costs were estimated based on experience observed in similar programs in other states and were reviewed for reasonableness by Mercer clinicians.

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Enhanced primary care management fee best estimates

The best estimates of the enhanced primary care management fees, as described above, are comprised of the seven fee components plus account management and overhead costs. They are designed to be paid for each CCN-S enrollee, regardless of which services they use. The PMPM enhanced primary care management fee best estimates for each population for the CY 2011 contract period are summarized in the table below:

Enhanced primary care management fee best estimates	TANF/LaCHIP-related populations	SSI-related populations
Prior Authorization	\$ 1.48	\$ 2.28
Patient Centered Medical Home	\$ 1.12	\$ 1.12
Care Coordination	\$ 0.49	\$ 0.49
Case Management and Chronic Care Management	\$ 2.02	\$ 5.90
Customer Service	\$ 0.45	\$ 0.45
Provider Monitoring and Service	\$ 0.53	\$ 0.53
Quality Management, Compliance and Fraud Monitoring	\$ 2.60	\$ 2.60
Account Management and Overhead	\$ 3.12	\$ 4.79
Total enhanced primary care management fee	\$ 11.81	\$ 18.16

Please note that the cost projections made by Mercer in the development of the above fees include the allocation of certain costs across more than one of the seven components. Therefore, the removal of any of the seven components from the services in the Provider Agreement would require recalculation of the rates. The effect of the removal of a component is not necessarily the amount shown for that component in the above table.

Savings reconciliation

It is the expectation of the State that the CCN-S model, with its additional fees, will achieve savings relative to the aggregate Per Capita Prepaid Benchmark (PCPB). To ensure the CCN-S entities are held financially accountable, the State has established a savings determination process as a part of the CCN-S contract for CY 2011.

The State will periodically compare the actual aggregate cost of authorized services as specified in CCN-S Provider Agreement and Policy and Procedure Guide, including the enhanced primary care



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case management fee for dates of services in the reconciliation period, to the aggregate PCPB. The PCPB will not include the PCP care management fees.

In the event that a CCN-S entity exceeds the Per Capita Prepaid Benchmark in the aggregate, the CCN-S entity will be required to refund up to 50% of the total amount of the enhanced primary care case management fees paid to the CCN during the reconciliation period. Conversely, CCN-S entities will be eligible for up to 60% of savings if the actual aggregate costs of authorized services, including enhanced primary care case management fees, are less than the aggregate PCPB. Due to limitations under the Medicaid State Plan, shared savings will be limited to 5% of the actual aggregate costs including the enhanced primary care case management fees paid.

Total ePCCM fee best estimates

The best estimates of the total ePCCM fees consist of the best estimates of the enhanced primary care management fees plus the PCP care management fee. The best estimates of the total ePCCM fees for each population on a PMPM basis for the CY 2011 contract period are summarized in the table below:

Total ePCCM fee best estimates	TANF/LaCHIP-related populations	SSI-related populations
Enhanced primary care management fee	\$ 11.81	\$ 18.16
PCP care management fee	\$ 3.00	\$ 3.00
Total enhanced Primary Care Case Management fee	\$ 14.81	\$ 21.16

In preparing the best estimates of the ePCCM fees, Mercer has used and relied upon eligibility and program design data and information supplied by the State. The State is responsible for the validity and completeness of the supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we have not audited it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

The ePCCM fee estimates developed by Mercer are actuarial projections of future contingent events. Actual costs for CCN-S entities will differ from these projections due to factors including, but not limited to differences in business models and management techniques, the geographic area(s) in which an entity chooses to operate, the specific needs of an entity's enrollees and the efficiencies and economies of scale that an entity is able to achieve. As such, these estimates should be interpreted as having a likely range of variability.

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Mercer has developed best estimates of the ePCCM fees on behalf of the State to support on-going program design decisions. Use of these enhanced primary care management fee estimates for any purpose beyond that stated may not be appropriate.

Potential CCN-S entities are advised that the use of these ePCCM fee estimates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these enhanced primary care management fee estimates by potential CCN-S entities for any purpose. Mercer recommends that any organization considering contracting with the State should analyze its own projected expenses and any other costs for comparison to the rates offered by the State before deciding whether to contract with the State.

This methodology letter assumes the reader is familiar with the CCN-S program, Medicaid eligibility rules and actuarial rating techniques. It is intended for the State and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals to understand the technical nature of these results. This document should only be reviewed in its entirety.

If you have any questions, please feel free to contact me at +1 602 522 6595 or Robert Butler at +1 850 294 9669.

Sincerely,

A handwritten signature in black ink, appearing to read 'F. Ronald Ogborne III'.

F. Ronald Ogborne III, FSA, CERA, MAAA
RO/hl

Copy:
Ann Donley, State
Emma Fontenot, State
Maddie McAndrew, State
Robert Butler, Mercer
Jennie Echols, Mercer

Appendix I
CCN-S Benchmark Summary

2011-2012 CCN-S Benchmark PMPM Summary

DHH Administrative Region Code	COA Code	COA Description	Rate Cell	Rate Cell Description	4/1/2011-6/30/2012	
					Member Months or Deliveries	CCN-S Preferred Benchmark PMPM PMPM or Cost/Delivery
02	01	SSI	01C	0-2 Months, Male and Female	207	\$ 16,759.57
02	01	SSI	02C	3-11 Months, Male and Female	1,167	\$ 3,580.34
02	01	SSI	03C	1-5 Years, Male and Female	12,096	\$ 671.62
02	01	SSI	04C	6-13 Years, Male and Female	26,226	\$ 197.80
02	01	SSI	05C	14-18 Years, Male and Female	17,438	\$ 210.40
02	01	SSI	06C	19-44 Years, Male and Female	48,235	\$ 547.46
02	01	SSI	07C	45+ Years, Male and Female	62,018	\$ 852.94
02	02	Family and Children	01C	0-2 Months, Male and Female	25,287	\$ 1,652.24
02	02	Family and Children	02C	3-11 Months, Male and Female	57,521	\$ 228.99
02	02	Family and Children	03C	1-5 Years, Male and Female	323,248	\$ 89.54
02	02	Family and Children	04C	6-13 Years, Male and Female	411,058	\$ 55.25
02	02	Family and Children	05F	14-18 Years, Female	118,733	\$ 89.92
02	02	Family and Children	05M	14-18 Years, Male	107,565	\$ 61.23
02	02	Family and Children	06F	19-44 Years, Female	152,275	\$ 210.77
02	02	Family and Children	06M	19-44 Years, Male	5,076	\$ 248.29
02	02	Family and Children	07F	45+ Years, Female	7,830	\$ 414.50
02	02	Family and Children	07M	45+ Years, Male	1,264	\$ 513.28
02	03	Foster Care Children	FLL	Foster Care, All Ages Male & Female	10,483	\$ 144.94
02	04	Breast and Cervical Cancer	BLL	BCC, All Ages Female	1,387	\$ 2,088.95
02	KI	Maternity Kickpayment	KLL	Maternity Kickpayment, All Ages	6,086	\$ 5,512.84
03	01	SSI	01C	0-2 Months, Male and Female	59	\$ 16,759.57
03	01	SSI	02C	3-11 Months, Male and Female	503	\$ 3,580.34
03	01	SSI	03C	1-5 Years, Male and Female	7,532	\$ 671.62
03	01	SSI	04C	6-13 Years, Male and Female	20,033	\$ 197.80
03	01	SSI	05C	14-18 Years, Male and Female	13,071	\$ 210.40
03	01	SSI	06C	19-44 Years, Male and Female	37,290	\$ 414.53
03	01	SSI	07C	45+ Years, Male and Female	45,523	\$ 775.51
03	02	Family and Children	01C	0-2 Months, Male and Female	16,268	\$ 1,252.99
03	02	Family and Children	02C	3-11 Months, Male and Female	38,673	\$ 249.02
03	02	Family and Children	03C	1-5 Years, Male and Female	205,301	\$ 105.80
03	02	Family and Children	04C	6-13 Years, Male and Female	258,065	\$ 66.97
03	02	Family and Children	05F	14-18 Years, Female	79,011	\$ 118.27
03	02	Family and Children	05M	14-18 Years, Male	72,826	\$ 79.19
03	02	Family and Children	06F	19-44 Years, Female	96,757	\$ 231.09
03	02	Family and Children	06M	19-44 Years, Male	4,450	\$ 248.29
03	02	Family and Children	07F	45+ Years, Female	3,245	\$ 414.50
03	02	Family and Children	07M	45+ Years, Male	903	\$ 513.28
03	03	Foster Care Children	FLL	Foster Care, All Ages Male & Female	6,353	\$ 144.94
03	04	Breast and Cervical Cancer	BLL	BCC, All Ages Female	947	\$ 2,088.95
03	KI	Maternity Kickpayment	KLL	Maternity Kickpayment, All Ages	3,973	\$ 5,320.17
09	01	SSI	01C	0-2 Months, Male and Female	84	\$ 16,759.57

2011-2012 CCN-S Benchmark PMPM Summary

09	01	SSI	02C	3-11 Months, Male and Female	501	\$	3,580.34
09	01	SSI	03C	1-5 Years, Male and Female	6,063	\$	671.62
09	01	SSI	04C	6-13 Years, Male and Female	14,913	\$	197.80
09	01	SSI	05C	14-18 Years, Male and Female	10,393	\$	210.40
09	01	SSI	06C	19-44 Years, Male and Female	37,648	\$	491.37
09	01	SSI	07C	45+ Years, Male and Female	54,364	\$	813.93
09	02	Family and Children	01C	0-2 Months, Male and Female	19,257	\$	1,386.91
09	02	Family and Children	02C	3-11 Months, Male and Female	43,914	\$	248.69
09	02	Family and Children	03C	1-5 Years, Male and Female	243,488	\$	113.77
09	02	Family and Children	04C	6-13 Years, Male and Female	317,285	\$	76.63
09	02	Family and Children	05F	14-18 Years, Female	88,066	\$	119.88
09	02	Family and Children	05M	14-18 Years, Male	82,691	\$	88.70
09	02	Family and Children	06F	19-44 Years, Female	97,890	\$	249.08
09	02	Family and Children	06M	19-44 Years, Male	5,724	\$	248.29
09	02	Family and Children	07F	45+ Years, Female	3,938	\$	414.50
09	02	Family and Children	07M	45+ Years, Male	1,597	\$	513.28
09	03	Foster Care Children	FLL	Foster Care, All Ages Male & Female	18,447	\$	144.94
09	04	Breast and Cervical Cancer	BLL	BCC, All Ages Female	1,836	\$	2,088.95
09	KI	Maternity Kickpayment	KLL	Maternity Kickpayment, All Ages	4,657	\$	5,233.82

COA = Category of Assistance
 RC = Rate Cell

2011-2012 CCN-S Benchmark PMPM Summary

DHH Administrative Region Code	COA Code	COA Description	Rate Cell	Rate Cell Description	10/1/2011-6/30/2012	
					Member Months or Deliveries	CCN-S Preferred Benchmark PMPM PMPM or Cost/Delivery
01	01	SSI	01C	0-2 Months, Male and Female	219	\$ 16,880.20
01	01	SSI	02C	3-11 Months, Male and Female	1,179	\$ 3,611.70
01	01	SSI	03C	1-5 Years, Male and Female	13,324	\$ 678.71
01	01	SSI	04C	6-13 Years, Male and Female	35,565	\$ 199.95
01	01	SSI	05C	14-18 Years, Male and Female	26,782	\$ 212.73
01	01	SSI	06C	19-44 Years, Male and Female	74,214	\$ 559.46
01	01	SSI	07C	45+ Years, Male and Female	95,796	\$ 911.38
01	02	Family and Children	01C	0-2 Months, Male and Female	33,309	\$ 1,434.28
01	02	Family and Children	02C	3-11 Months, Male and Female	77,052	\$ 224.35
01	02	Family and Children	03C	1-5 Years, Male and Female	407,924	\$ 95.62
01	02	Family and Children	04C	6-13 Years, Male and Female	473,630	\$ 58.04
01	02	Family and Children	05F	14-18 Years, Female	144,573	\$ 92.89
01	02	Family and Children	05M	14-18 Years, Male	126,794	\$ 66.84
01	02	Family and Children	06F	19-44 Years, Female	222,415	\$ 203.79
01	02	Family and Children	06M	19-44 Years, Male	8,668	\$ 251.24
01	02	Family and Children	07F	45+ Years, Female	12,222	\$ 419.49
01	02	Family and Children	07M	45+ Years, Male	2,933	\$ 519.31
01	03	Foster Care Children	FLL	Foster Care, All Ages Male & Female	13,168	\$ 146.63
01	04	Breast and Cervical Cancer	BLL	BCC, All Ages Female	1,838	\$ 2,114.47
01	KI	Maternity Kickpayment	KLL	Maternity Kickpayment, All Ages	7,997	\$ 7,003.57
07	01	SSI	01C	0-2 Months, Male and Female	261	\$ 16,880.20
07	01	SSI	02C	3-11 Months, Male and Female	1,458	\$ 3,611.70
07	01	SSI	03C	1-5 Years, Male and Female	11,890	\$ 678.71
07	01	SSI	04C	6-13 Years, Male and Female	28,000	\$ 199.95
07	01	SSI	05C	14-18 Years, Male and Female	20,419	\$ 212.73
07	01	SSI	06C	19-44 Years, Male and Female	52,763	\$ 501.68
07	01	SSI	07C	45+ Years, Male and Female	62,252	\$ 786.88
07	02	Family and Children	01C	0-2 Months, Male and Female	21,878	\$ 1,808.96
07	02	Family and Children	02C	3-11 Months, Male and Female	49,733	\$ 272.30
07	02	Family and Children	03C	1-5 Years, Male and Female	275,837	\$ 105.23
07	02	Family and Children	04C	6-13 Years, Male and Female	347,700	\$ 61.11
07	02	Family and Children	05F	14-18 Years, Female	101,057	\$ 111.53
07	02	Family and Children	05M	14-18 Years, Male	89,481	\$ 67.73
07	02	Family and Children	06F	19-44 Years, Female	109,071	\$ 244.51
07	02	Family and Children	06M	19-44 Years, Male	2,903	\$ 251.24
07	02	Family and Children	07F	45+ Years, Female	3,663	\$ 419.49
07	02	Family and Children	07M	45+ Years, Male	773	\$ 519.31
07	03	Foster Care Children	FLL	Foster Care, All Ages Male & Female	12,824	\$ 146.63

2011-2012 CCN-S Benchmark PMPM Summary

07	04	Breast and Cervical Cancer	BLL	BCC, All Ages Female	1,127	\$	2,114.47
07	KI	Maternity Kickpayment	KLL	Maternity Kickpayment, All Ages	5,174	\$	5,410.75
08	01	SSI	01C	0-2 Months, Male and Female	89	\$	16,880.20
08	01	SSI	02C	3-11 Months, Male and Female	548	\$	3,611.70
08	01	SSI	03C	1-5 Years, Male and Female	7,697	\$	678.71
08	01	SSI	04C	6-13 Years, Male and Female	16,918	\$	199.95
08	01	SSI	05C	14-18 Years, Male and Female	12,053	\$	212.73
08	01	SSI	06C	19-44 Years, Male and Female	35,398	\$	438.84
08	01	SSI	07C	45+ Years, Male and Female	42,394	\$	818.92
08	02	Family and Children	01C	0-2 Months, Male and Female	15,966	\$	1,659.00
08	02	Family and Children	02C	3-11 Months, Male and Female	36,468	\$	330.80
08	02	Family and Children	03C	1-5 Years, Male and Female	209,696	\$	130.43
08	02	Family and Children	04C	6-13 Years, Male and Female	276,007	\$	71.86
08	02	Family and Children	05F	14-18 Years, Female	80,904	\$	114.77
08	02	Family and Children	05M	14-18 Years, Male	75,970	\$	76.77
08	02	Family and Children	06F	19-44 Years, Female	94,868	\$	225.84
08	02	Family and Children	06M	19-44 Years, Male	4,070	\$	251.24
08	02	Family and Children	07F	45+ Years, Female	3,652	\$	419.49
08	02	Family and Children	07M	45+ Years, Male	721	\$	519.31
08	03	Foster Care Children	FLL	Foster Care, All Ages Male & Female	9,146	\$	146.63
08	04	Breast and Cervical Cancer	BLL	BCC, All Ages Female	1,190	\$	2,114.47
08	KI	Maternity Kickpayment	KLL	Maternity Kickpayment, All Ages	3,950	\$	5,366.36

COA = Category of Assistance
 RC = Rate Cell

2011-2012 CCN-S Benchmark PMPM Summary

DHH Administrative Region Code	COA Code	COA Description	Rate Cell	Rate Cell Description	4/1/2012-6/30/2012	
					Member Months or Deliveries	CCN-S Preferred Benchmark PMPM PMPM or Cost/Delivery
04	01	SSI	01C	0-2 Months, Male and Female	227	\$ 17,001.86
04	01	SSI	02C	3-11 Months, Male and Female	951	\$ 3,643.39
04	01	SSI	03C	1-5 Years, Male and Female	9,020	\$ 685.88
04	01	SSI	04C	6-13 Years, Male and Female	19,153	\$ 202.13
04	01	SSI	05C	14-18 Years, Male and Female	13,146	\$ 215.08
04	01	SSI	06C	19-44 Years, Male and Female	50,893	\$ 499.21
04	01	SSI	07C	45+ Years, Male and Female	74,412	\$ 812.83
04	02	Family and Children	01C	0-2 Months, Male and Female	25,508	\$ 1,517.34
04	02	Family and Children	02C	3-11 Months, Male and Female	57,298	\$ 259.68
04	02	Family and Children	03C	1-5 Years, Male and Female	312,288	\$ 107.73
04	02	Family and Children	04C	6-13 Years, Male and Female	404,748	\$ 68.88
04	02	Family and Children	05F	14-18 Years, Female	115,330	\$ 106.08
04	02	Family and Children	05M	14-18 Years, Male	106,732	\$ 71.26
04	02	Family and Children	06F	19-44 Years, Female	131,186	\$ 227.21
04	02	Family and Children	06M	19-44 Years, Male	6,229	\$ 254.23
04	02	Family and Children	07F	45+ Years, Female	4,880	\$ 424.55
04	02	Family and Children	07M	45+ Years, Male	1,691	\$ 525.42
04	03	Foster Care Children	FLL	Foster Care, All Ages Male & Female	16,960	\$ 148.33
04	04	Breast and Cervical Cancer	BLL	BCC, All Ages Female	1,465	\$ 2,140.10
04	KI	Maternity Kickpayment	KLL	Maternity Kickpayment, All Ages	6,265	\$ 4,682.14
05	01	SSI	01C	0-2 Months, Male and Female	99	\$ 17,001.86
05	01	SSI	02C	3-11 Months, Male and Female	402	\$ 3,643.39
05	01	SSI	03C	1-5 Years, Male and Female	4,152	\$ 685.88
05	01	SSI	04C	6-13 Years, Male and Female	9,344	\$ 202.13
05	01	SSI	05C	14-18 Years, Male and Female	5,466	\$ 215.08
05	01	SSI	06C	19-44 Years, Male and Female	19,741	\$ 437.19
05	01	SSI	07C	45+ Years, Male and Female	28,274	\$ 732.54
05	02	Family and Children	01C	0-2 Months, Male and Female	11,860	\$ 1,340.28
05	02	Family and Children	02C	3-11 Months, Male and Female	27,319	\$ 291.30
05	02	Family and Children	03C	1-5 Years, Male and Female	147,338	\$ 124.09
05	02	Family and Children	04C	6-13 Years, Male and Female	188,069	\$ 74.85
05	02	Family and Children	05F	14-18 Years, Female	52,072	\$ 116.59
05	02	Family and Children	05M	14-18 Years, Male	49,058	\$ 77.49
05	02	Family and Children	06F	19-44 Years, Female	51,041	\$ 253.39
05	02	Family and Children	06M	19-44 Years, Male	2,379	\$ 254.23
05	02	Family and Children	07F	45+ Years, Female	1,420	\$ 424.55
05	02	Family and Children	07M	45+ Years, Male	492	\$ 525.42
05	03	Foster Care Children	FLL	Foster Care, All Ages Male & Female	9,247	\$ 148.33

2011-2012 CCN-S Benchmark PMPM Summary

05	04	Breast and Cervical Cancer	BLL	BCC, All Ages Female	749	\$	2,140.10
05	KI	Maternity Kickpayment	KLL	Maternity Kickpayment, All Ages	2,839	\$	4,965.43
06	01	SSI	01C	0-2 Months, Male and Female	117	\$	17,001.86
06	01	SSI	02C	3-11 Months, Male and Female	593	\$	3,643.39
06	01	SSI	03C	1-5 Years, Male and Female	6,157	\$	685.88
06	01	SSI	04C	6-13 Years, Male and Female	14,344	\$	202.13
06	01	SSI	05C	14-18 Years, Male and Female	9,168	\$	215.08
06	01	SSI	06C	19-44 Years, Male and Female	33,245	\$	396.08
06	01	SSI	07C	45+ Years, Male and Female	40,719	\$	772.42
06	02	Family and Children	01C	0-2 Months, Male and Female	12,936	\$	1,557.14
06	02	Family and Children	02C	3-11 Months, Male and Female	28,932	\$	274.83
06	02	Family and Children	03C	1-5 Years, Male and Female	163,279	\$	117.13
06	02	Family and Children	04C	6-13 Years, Male and Female	217,627	\$	74.07
06	02	Family and Children	05F	14-18 Years, Female	62,296	\$	120.55
06	02	Family and Children	05M	14-18 Years, Male	58,868	\$	84.98
06	02	Family and Children	06F	19-44 Years, Female	62,428	\$	241.21
06	02	Family and Children	06M	19-44 Years, Male	2,967	\$	254.23
06	02	Family and Children	07F	45+ Years, Female	1,822	\$	424.55
06	02	Family and Children	07M	45+ Years, Male	625	\$	525.42
06	03	Foster Care Children	FLL	Foster Care, All Ages Male & Female	10,826	\$	148.33
06	04	Breast and Cervical Cancer	BLL	BCC, All Ages Female	658	\$	2,140.10
06	KI	Maternity Kickpayment	KLL	Maternity Kickpayment, All Ages	3,207	\$	5,066.20